CONFIDENTIAL HEALTH HISTORY

Patient Name: _____ Date of Birth: _____

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. **Yes / No** Has there been a change in your health within the last year?

   If YES, explain: _____

III. HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No	Heart disease	**Yes / No**	AIDS/HIV	**Yes / No**	Psychiatric care
Yes / No	Family history of heart disease	**Yes / No**	Surgeries	**Yes / No**	Osteoporosis
Yes / No	Heart attack	**Yes / No**	Hospitalization	**Yes / No**	Thyroid disease
Yes / No	Artificial joint	**Yes / No**	Diabetes	**Yes / No**	Asthma
Yes / No	Stomach problems or ulcers	**Yes / No**	Family history of diabetes	**Yes / No**	Hepatitis
Yes / No	Heart defects	**Yes / No**	Tumors or cancer	**Yes / No**	Sexual transmitted disease
Yes / No	Heart murmurs	**Yes / No**	Chemotherapy	**Yes / No**	Herpes
Yes / No	Rheumatic fever	**Yes / No**	Radiation	**Yes / No**	Canker or cold sores
Yes / No	Skin disease	**Yes / No**	Arthritis, rheumatism	**Yes / No**	Anemia
Yes / No	Hardening of arteries	**Yes / No**	Emphysema or lung disease	**Yes / No**	Liver disease
Yes / No	High blood pressure	**Yes / No**	Kidney or bladder disease	**Yes / No**	Eye disease
Yes / No	Seizures	**Yes / No**	Stroke	**Yes / No**	Transplants
Yes / No	Cosmetic surgery	**Yes / No**	Eating disorders	**Yes / No**	Tuberculosis

Other: _____

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No	Aspirin	**Yes / No**	Valium or sedatives	**Yes / No**	Codeine or other opioids
Yes / No	Penicillin or other antibiotics	**Yes / No**	Latex	**Yes / No**	Food
Yes / No	Nitrous oxide	**Yes / No**	Metal	**Yes / No**	Local anesthetic

Others: _____

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS? (Please circle Yes or No for each)

Yes / No	Recreational drugs	**Yes / No**	Tobacco in any form	**Yes / No**	Antibiotics
Yes / No	Weight loss medications	**Yes / No**	Bisphosphonate (Fosamax)	**Yes / No**	Alcohol

Please list **ALL medications** that you are taking:

VII. ALL PATIENTS (Please circle Yes or No for each)

Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, please explain: _____

_____

Yes / No Have you ever been pre-medicated for dental treatment? If YES, why: _____

Yes / No Have you ever taken Fen-Phen? If YES, when: _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____ _____ _____

Signature of Patient (Parent or Guardian) Date Signature of Dentist Date