

# HEALTH HISTORY

TODAY'S DATE: \_\_\_\_\_

PATIENTS NAME:(LAST) \_\_\_\_\_ (FIRST) \_\_\_\_\_ DO YOU SMOKE? YES NO ARE YOU PREGNANT? YES NO if yes, due date \_\_\_\_\_  
 PHYSICIAN NAME: \_\_\_\_\_ IN CASE OF EMERGENCY: NEXT OF KIN OR FRIEND; \_\_\_\_\_  
 PHYSICIAN ADDRESS: \_\_\_\_\_ NAME \_\_\_\_\_  
 LAST MEDICAL EXAM: \_\_\_\_\_ MONTH \_\_\_\_\_ YEAR \_\_\_\_\_ ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

DO YOU NEED TO TAKE ANTIBIOTIC PREMEDICATION PRIOR TO DENTAL TREATMENT? YES NO DON'T KNOW  
 NAME OF ANTIBIOTIC \_\_\_\_\_

### DO YOU HAVE OR HAVE YOU EVER HAD? (PLEASE CIRCLE Y OR N)

RADIATION TREATMENT FOR DISEASE-----	Y	N	RHEUMATIC FEVER-----	Y	N
CANCER-----	Y	N	CHEMICAL DEPENDENCY-----	Y	N
ARTIFICIAL JOINTS/PROSTHESIS-----	Y	N	HIV/AIDS-----	Y	N
ULCER-----	Y	N	ABNORMAL BLEEDING-----	Y	N
ANEMIA-----	Y	N	LUNG DISEASE-----	Y	N
DIABETES-----	Y	N	PACEMAKER-----	Y	N
BLOOD PRESSURE (HIGH OR LOW - Circle one)-----	Y	N	ASPIRIN THERAPY-----	Y	N
ARTHRITIS-----	Y	N	ASTHMA-----	Y	N
TUBERCULOSIS-----	Y	N	LIVER PROBLEMS/DYSFUNCTION-----	Y	N
EPILEPSY-----	Y	N	HEPATITIS-----	Y	N
HEART MURMUR-----	Y	N	THYROID DYSFUNCTION-----	Y	N
HEART RELATED PROBLEMS-----	Y	N	KIDNEY DISEASE-----	Y	N
NERVOUS DISORDER-----	Y	N	PSYCHIATRIC DISORDER-----	Y	N

OFFICE USE ONLY

Initial Review \_\_\_\_\_  
 (date & initials)

DATE \_\_\_\_\_ INITIALS \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

ANY MEDICAL CONDITIONS NOT LISTED: \_\_\_\_\_

### ALLERGIC TO: (Y OR N)

ANTIBIOTICS-----	Y	N	IF YES, WHAT?
ANESTHETICS-----	Y	N	IF YES, WHAT?
LATEX-----	Y	N	EXPLAIN:
OTHER-----	Y	N	IF YES, WHAT?

### LIST CURRENT MEDICATIONS & THE CORRELATING DIAGNOSIS:

#1	FOR
#2	FOR
#3	FOR
#4	FOR

**NOTE: A CHANGE IN YOUR HEALTH STATUS SHOULD BE REPORTED TO THE OFFICE AT THE EARLIEST POSSIBLE TIME.**

### PERMISSION TO RELEASE HEALTH INFORMATION

I GRANT THE RIGHT TO THE DENTIST TO RELEASE HEALTH INFORMATION OBTAINED FROM ME, AND INFORMATION ABOUT MY DENTAL TREATMENT TO THIRD PARTY PAYORS, AND/OR OTHER HEALTH PRACTITIONERS, AND TO CHARGE A REASONABLE FEE FOR TRANSFER OR DUPLICATION OF RADIOGRAPHS AND RECORDS AS WELL AS ADMINISTRATIVE SERVICES. I UNDERSTAND THAT MY RECORDS MAY BE KEPT ON PREMISES UP TO 2 YEARS AFTER NON-ACTIVITY AND MAY/CAN BE DESTROYED AFTER 3 YEARS. I UNDERSTAND THAT I MUST REQUEST MY RECORDS IN WRITING PRIOR TO STORAGE.

TO THE BEST OF MY KNOWLEDGE, THE ABOVE HEALTH HISTORY QUESTIONS HAVE BEEN ACCURATELY ANSWERED.

PERSON COMPLETING FORM; SIGNATURE \_\_\_\_\_ PRINT NAME \_\_\_\_\_

IF OTHER THAN PATIENT, INDICATE RELATIONSHIP: \_\_\_\_\_ DATE \_\_\_\_\_

Patient's Name \_\_\_\_\_

# Health History Update

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Date: \_\_\_\_\_

Current Medications

Health Changes: \_\_\_\_\_

1. \_\_\_\_\_

\_\_\_\_\_

2. \_\_\_\_\_

\_\_\_\_\_

3. \_\_\_\_\_

\_\_\_\_\_

4. \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Staff's Name: \_\_\_\_\_

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Date: \_\_\_\_\_

Current Medications

Health Changes: \_\_\_\_\_

1. \_\_\_\_\_

\_\_\_\_\_

2. \_\_\_\_\_

\_\_\_\_\_

3. \_\_\_\_\_

\_\_\_\_\_

4. \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Staff's Name: \_\_\_\_\_

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Date: \_\_\_\_\_

Current Medications

Health Changes: \_\_\_\_\_

1. \_\_\_\_\_

\_\_\_\_\_

2. \_\_\_\_\_

\_\_\_\_\_

3. \_\_\_\_\_

\_\_\_\_\_

4. \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Staff's Name: \_\_\_\_\_

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Date: \_\_\_\_\_

Current Medications

Health Changes: \_\_\_\_\_

1. \_\_\_\_\_

\_\_\_\_\_

2. \_\_\_\_\_

\_\_\_\_\_

3. \_\_\_\_\_

\_\_\_\_\_

4. \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Staff's Name: \_\_\_\_\_

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