

# PATIENT HEALTH HISTORY

**Patient's Name** \_\_\_ Dr. \_\_\_ Mr. \_\_\_ Mrs. \_\_\_ Ms. \_\_\_\_\_

Marital Status \_\_\_ single \_\_\_ married \_\_\_ divorced \_\_\_ widowed \_\_\_ Male \_\_\_ Female

Home Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_ Date of Birth \_\_\_\_\_

Home Phone \_\_\_\_\_ Bus. Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Social Security # \_\_\_\_\_ Referred by: \_\_\_\_\_

Call in Case of Emergency \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_

Primary Insured Person (if not same as patient) \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

**Medical Health**

Are you currently under care of a physician? Yes \_\_\_ No \_\_\_

Name and address of physician \_\_\_\_\_ Phone \_\_\_\_\_

Last complete physical? \_\_\_\_\_

Are you taking any medication now? Yes \_\_\_ No \_\_\_ For what purpose? \_\_\_\_\_

If yes, name of medication \_\_\_\_\_

Have you ever been treated for:

- Heart Disease Yes \_\_\_ No \_\_\_
- Rheumatic Fever Yes \_\_\_ No \_\_\_
- Congenital Heart Yes \_\_\_ No \_\_\_
- Mitral Valve Prolapse Yes \_\_\_ No \_\_\_
- Heart Murmur Yes \_\_\_ No \_\_\_
- Artificial Replacements (hip or knee) Yes \_\_\_ No \_\_\_
- Abnormal Blood Pressure Yes \_\_\_ No \_\_\_
- Ulcers Yes \_\_\_ No \_\_\_
- Tuberculosis or Lung Disease Yes \_\_\_ No \_\_\_
- Cardiac Pacemaker Yes \_\_\_ No \_\_\_
- Metal Pins/Rods Yes \_\_\_ No \_\_\_

- HIV Yes \_\_\_ No \_\_\_
- Jaundice Yes \_\_\_ No \_\_\_
- Asthma or Hay Fever Yes \_\_\_ No \_\_\_
- Sinus Trouble Yes \_\_\_ No \_\_\_
- Chronic Cough Yes \_\_\_ No \_\_\_
- Hepatitis Yes \_\_\_ No \_\_\_
- Arthritis Yes \_\_\_ No \_\_\_
- Stroke Yes \_\_\_ No \_\_\_
- Glaucoma Yes \_\_\_ No \_\_\_
- Epilepsy Yes \_\_\_ No \_\_\_
- Anemia Yes \_\_\_ No \_\_\_
- Diabetes Yes \_\_\_ No \_\_\_
- Cancer Yes \_\_\_ No \_\_\_

Are you allergic to: Penicillin \_\_\_ Codeine \_\_\_ Local injected anesthetics \_\_\_ Other medications \_\_\_\_\_

Do you have excessive urination and/or thirst? Yes \_\_\_ No \_\_\_

Are you pregnant? Yes \_\_\_ No \_\_\_

Do you take aspirin or blood thinners daily? Yes \_\_\_ No \_\_\_

**Dental Health**

Reason for visit: \_\_\_\_\_

When was your last dental visit? \_\_\_\_\_

Have you ever had any serious problems associated with previous dental treatment? Yes \_\_\_ No \_\_\_

If so, explain: \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_

What texture brush do you use? soft \_\_\_ medium \_\_\_ hard \_\_\_ nylon \_\_\_ natural \_\_\_

How often do you floss? \_\_\_\_\_

Do your gums bleed while brushing? \_\_\_\_\_

Do your gums bleed while flossing? \_\_\_\_\_

Please add anything you feel is important: \_\_\_\_\_

\_\_\_\_\_  
(Patient signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
(Parent/Guardian signature if patient is under age 18)