

Dental History Form

Date _____

Patient Name: _____ Home #: _____
 Address: _____ Work #: _____
 City: _____ State: _____ Zip Code: _____ SS#: _____
 Employer: _____ Date of Birth: _____
 Referred by: _____ E-Mail: _____
 Insurance Holder: Name: _____ SS#: _____
 (Primary) Date of Birth: _____ Employer: _____
 Ins. Comp: _____
 Relation to Patient: Self / Spouse / Parent
 Insurance Holder: Name: _____ SS#: _____
 (Secondary) Date of Birth: _____ Employer: _____
 Ins. Comp: _____
 Relation to Patient: Self / Spouse / Parent
 Nearest Relative: _____ Relationship: _____
 Phone #: _____ Cell #: _____

Please answer the following questions as fully as possible. This is for our records only and will be considered confidential. The doctor may have additional questions concerning your health when he sees you. Thank You.

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|--|-----|----|
| 1) Are you in good health? | YES | NO |
| 2) Had there been a change in your general health within the past year? | YES | NO |
| 3) My last physical exam was on _____ | | |
| 4) Are you now under the care of a physician? | YES | NO |
| If so, for what are you being treated? _____ | | |
| 5) Your Physician's Name and phone _____ | | |
| 6) Have you had any serious illness, operation or been hospitalized in the past 5 years? | YES | NO |
| If so, what? _____ | | |
| 7) Are you taking any medicine(s) Including non-prescription medicines? | YES | NO |
| If so, what? _____ | | |
| 8) Do you have or have you had any of the following conditions? Please circle specifics | | |
| A. Damaged heart valves, artificial heart valves, heart murmur, rheumatic heart disease
Mitral-valve prolapse (MVP) | | |
| B. Cardiovascular disease: heart trouble, heart attack angina, coronary insufficiency
coronary occlusion, high/low blood pressure, arteriosclerosis, stroke | | |
| 1) Do you have chest pain upon exertion? | YES | NO |
| 2) Are you ever short of breath after mild exertion or when lying down? | YES | NO |
| 3) Do your ankles swell? | YES | NO |
| 4) Do you have inborn heart defects? | YES | NO |
| 5) So you have a cardiac pacemaker? | YES | NO |
| C. Allergies (to what?) _____ | YES | NO |
| D. Sinus Trouble | YES | NO |
| E. Asthma or Hay Fever (if so, which one?) | YES | NO |
| F. Epilepsy, fainting spells, seizures, other neurological disorders | YES | NO |
| G. Persistent diarrhea or recent weight loss | YES | NO |
| H. Diabetes | YES | NO |
| I. Hepatitis, Jaundice or Liver Disease | YES | NO |
| J. AIDS or HIV infection | YES | NO |
| K. Thyroid problems | YES | NO |
| L. Respiratory problems, Emphysema, Bronchitis, etc..... | YES | NO |
| M. Arthritis or painful swollen joints..... | YES | NO |
| N. Stomach ulcer or hyperacidity..... | YES | NO |
| O. Kidney trouble | YES | NO |
| P. Tuberculosis | YES | NO |
| Q. Persistent cough or cough that produces blood..... | YES | NO |
| R. Persistent swollen glands in neck..... | YES | NO |
| S. Sexually transmitted disease..... | YES | NO |

