ESSENTIAL DENTAL CARE

HEALTH HISTORY QUESTIONAIRE

1. Have you had any health problems in the past five (5) years? . . . . . □ Yes □ No
2. Have you seen a physician or other health care provider in the past two (2) years? . . . . . □ Yes □ No
   Physician's Name: _____ Phone # or City: _____
   Dentist's Name: _____ Phone # or City: _____
3. Is there any activity you doctor says you can't do? . . . . . □ Yes □ No
4. Have you been hospitalized or had a serious illness in the past five (5) years? . . . . . □ Yes □ No
5. Have you ever had a bleeding problem? . . . . . □ Yes □ No

Baseline Vital Signs	Pulse	B.P.	Taken by:
			Reviewed by: Date:

Please circle the appropriate response as to whether or not you have or have ever had the following. If you are unsure, *do not* answer the question.

HEART/BLOOD VESSELS

Rhematic Fever	Yes	No
Rhematic Heart Damage	Yes	No
Heart Valve Damage	Yes	No
Heart Murmur	Yes	No
Congenital Heart Defect	Yes	No
Artificial Heart Valve	Yes	No
Prolapsed Heart Valve	Yes	No
High Blood Pressure	Yes	No
Heart Attack (Date:_____)	Yes	No
TIA/Stroke (Date:_____)	Yes	No
Heart Surgery (Date:_____)	Yes	No
Vascular Surgery (Date:_____)	Yes	No
Pacemaker	Yes	No
Coronary Heart Failure	Yes	No
Congestive Heart Failure	Yes	No
Angina Pectoris/Chest Pain	Yes	No
Irregular/Rapid Heartbeat	Yes	No
Other heart or vessel disorder	Yes	No

If yes, please list: _____

BLOOD

Blood Clots or Thrombosis	Yes	No
Anemia	Yes	No
Sickle Cell Disease/Trait	Yes	No
Hemophilia	Yes	No
Transfusion (Date:_____)	Yes	No
Bruise easily for no apparent reason	Yes	No
Other blood disorder	Yes	No

If yes, please list: _____

NERVOUS SYSTEM

Blood Clots or Thrombosis	Yes	No
Epilepsy	Yes	No
Seizure Disorder	Yes	No
Multiple Sclerosis	Yes	No
Trigeminal Neuralalgia	Yes	No
Chronic Pain	Yes	No
Anxiety/Depression	Yes	No
Alzheimer's Disease/Dementia	Yes	No
Psychiatric Treatment	Yes	No
Psychological Counseling	Yes	No
Persistent Dizziness/Fainting Spells	Yes	No
Persistent Numbness/Tingling	Yes	No
Other Nervous System/Mental Disorders	Yes	No

If yes, please list: _____

Head and Neck

Glaucoma	Yes	No
Chronic Sinusitis	Yes	No
Injury to head, neck, jaw or teeth	Yes	No
Headaches	Yes	No
Unexplained vision change	Yes	No
Frequent or severe nosebleeds	Yes	No
Persistant sore throat or hoarseness	Yes	No
Recurrent neckache or neck pain	Yes	No
Recent difficulty swallowing		

ENDOCRINE SYSTEM

Diabetes	Yes	No
Hypothyroid	Yes	No
Hyperthyroid	Yes	No
Parathyroid	Yes	No
Other Thyroid Condition	Yes	No

If yes, please list: _____

Cushing's Syndrome	Yes	No
Other Endocrine Condition	Yes	No

If yes, please list: _____

MUSCULOSKELETAL/CONNECTIVE TISSUE

Sjogren's Syndrome	Yes	No
Arthritis	Yes	No
Artificial Joint (Date:_____) Type: _____	Yes	No
Fibromyalgia/Rheumatism	Yes	No
Chronic Back Pain	Yes	No
Other Muscle or Bone Disorder	Yes	No

If yes, please list: _____

RESPIRATORY

Tuberculosis (TB)	Yes	No
Asthma	Yes	No
Chronic Bronchitis	Yes	No
Emphysema	Yes	No
Persistant Cough	Yes	No
Cough up bloody sputum	Yes	No
Shortness of Breath	Yes	No
Other Respiratory disorder	Yes	No

If yes, please list: _____

PLEASE TURN OVER!

URINARY TRACT

Kidney Disease	Yes	No
Renal Dialysis	Yes	No
Venereal Disease	Yes	No
Sexually Transmitted Disease	Yes	No
Other Urinary disease	Yes	No

If yes, please list: _____

DIGESTIVE SYSTEM

Hepatitis (Type: _____)	Yes	No
Cirrhosis of the Liver/ Liver Disease	Yes	No
Ulcers	Yes	No
Jaundice	Yes	No
Frequent Heartburn or Reflux	Yes	No
Frequent Nausea/Vomiting	Yes	No
Other Digestive Disorder	Yes	No

If yes, please list: _____

CANCER HISTORY

Cancer	Yes	No

If yes, please list: _____

Leukemia	Yes	No
Benign tumors/growths	Yes	No
Type of Treatment:		
Surgery	Yes	No
Radiation Therapy	Yes	No
Chemotherapy	Yes	No
Hormone Therapy	Yes	No

ALLERGY HISTORY

Are you allergic to, or have you ever had a bad reaction to, any of the following?

Dental Anesthetics	Yes	No
Penicillin	Yes	No
Sulfa Drugs	Yes	No
Other Antibiotics	Yes	No
Aspirin	Yes	No
Latex Products	Yes	No
Metals, including jewelry	Yes	No
Other allergies:	Yes	No

If yes, please list: _____

FAMILY HISTORY

Has anyone in your family (grandparent, parent, sibling, child) ever had:

Diabetes
Heart Disease
Depression or Anxiety
Tuberculosis
Any disorder that "runs in" your family

If yes, please list: _____

ESSENTIAL DENTAL CARE

MISCELLANEOUS

Lupus Erythematosus	Yes	No
Organ transplant	Yes	No
If yes, please list: _____		
Suppressed Immune System	Yes	No
Persistent Fever	Yes	No
Taken steriod/prednisone	Yes	No
Tested positive for HIV	Yes	No
Been diagnosed with AIDS	Yes	No
Taken prescription diet pills	Yes	No

If yes, please check type:

□ Pondium □ Phen-fen

□ Redux □ Other: _____

MISCELLANEOUS (continued)

Use tobacco products	Yes	No
If yes, what type? _____		
How much?_____ How long?_____		
Still using tobacco?	Yes	No
Would you like to quit?	Yes	No
Quit on? (Date:_____)		
Drink alcoholic beverages	Yes	No
If yes, how much? _____		
Use methamphetamine, amphetamines, or "speed"?	Yes	No
Use intravenous drugs?	Yes	No
Use cocaine or "crack"?	Yes	No

MISCELLANEOUS (continued)

Use any other recreational drug?	Yes	No
Are you a recovering alcoholic or addict?	Yes	No

WOMEN ONLY

Are you pregnant or is there a possibility that you may be pregnant?	Yes	No
If yes, due date: _____		
Are you breastfeeding?	Yes	No
Are you in, or have you passed through menopause (change of life)?	Yes	No

Do you have any other condition you think we should know about? □ Yes □ No _____

_____

Please circle all the medications you are currently taking:

Heart	Blood Thinners	Hormones	Antibiotics	Tranquilizers
Nitroglycerin	Blood Pressure	Insulin/Diabetic drug	Antihistamine	Antidepressants
Digitalis	Oral Contraceptive	Thyroid	Cyclosporint A	Pain
Aspirin (__tabs/day)	Steroids/Cortisone	Nifedipine		

List medication names and dosages (include over-the-counter, herbal, and nutritional supplements):

_____

_____

_____

_____

_____

My health history as presented is complete and correct to the best of my knowledge.

Signature of Patient, Parent, or Guardian _____ Date: _____

Comments: (Dentist or Staff)

_____

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