

HEALTH HISTORY

Patient's Name _____

Age _____

DO YOU HAVE NOW, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING?

YES		NO		YES		NO		YES		NO		
1. Heart disease; heart attack	<input type="checkbox"/>	<input type="checkbox"/>	18. Difficulty opening or closing jaw	<input type="checkbox"/>	<input type="checkbox"/>	35. Sickle cell anemia	<input type="checkbox"/>	<input type="checkbox"/>				
2. Abnormal heart rhythm	<input type="checkbox"/>	<input type="checkbox"/>	19. Psychiatric care	<input type="checkbox"/>	<input type="checkbox"/>	36. Leukemia	<input type="checkbox"/>	<input type="checkbox"/>				
3. A pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	20. Substance abuse (alcohol, drugs)	<input type="checkbox"/>	<input type="checkbox"/>	37. Other blood disorders	<input type="checkbox"/>	<input type="checkbox"/>				
4. Heart surgery	<input type="checkbox"/>	<input type="checkbox"/>	21. Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	38. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>				
5. Chest pains or angina	<input type="checkbox"/>	<input type="checkbox"/>	22. Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	39. Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>				
6. Swelling of ankles	<input type="checkbox"/>	<input type="checkbox"/>	23. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	40. Persistent cough	<input type="checkbox"/>	<input type="checkbox"/>				
7. Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	24. Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	41. Emphysema	<input type="checkbox"/>	<input type="checkbox"/>				
8. Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	25. Cancer	<input type="checkbox"/>	<input type="checkbox"/>	42. Asthma	<input type="checkbox"/>	<input type="checkbox"/>				
9. High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	26. Benign tumors or growths	<input type="checkbox"/>	<input type="checkbox"/>	43. Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>				
10. Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	27. Radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>	44. Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>				
11. Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	28. Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	45. Allergies	<input type="checkbox"/>	<input type="checkbox"/>				
12. Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	29. Marked weight change (non-dieting)	<input type="checkbox"/>	<input type="checkbox"/>	46. Hepatitis or liver disease	<input type="checkbox"/>	<input type="checkbox"/>				
13. Artificial heart valves	<input type="checkbox"/>	<input type="checkbox"/>	30. Blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>	47. Frequent nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>				
14. Artificial (prosthetic) joints	<input type="checkbox"/>	<input type="checkbox"/>	31. Herpes	<input type="checkbox"/>	<input type="checkbox"/>	48. Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>				
15. Stroke	<input type="checkbox"/>	<input type="checkbox"/>	32. Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>	49. Epilepsy or seizure disorders	<input type="checkbox"/>	<input type="checkbox"/>				
16. Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	33. Anemia	<input type="checkbox"/>	<input type="checkbox"/>	50. Dizziness/fainting	<input type="checkbox"/>	<input type="checkbox"/>				
17. Clicking/popping of the jaw	<input type="checkbox"/>	<input type="checkbox"/>	34. Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	51. Frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>				
										YES	NO	
52. Have you been under the care of a physician at any time within the past 2 years?											<input type="checkbox"/>	<input type="checkbox"/>
If so, for what reason? _____												
53. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma?											<input type="checkbox"/>	<input type="checkbox"/>
54. Do you use tobacco in any form?											<input type="checkbox"/>	<input type="checkbox"/>
If so, how much per day and what type? _____												
55. Have you ever received a general anesthetic? (Been put to sleep for surgery)											<input type="checkbox"/>	<input type="checkbox"/>
If so, did you have any adverse reaction to it? _____												
56. Do you have any disease, condition, or problem not listed above that you think should be noted?											<input type="checkbox"/>	<input type="checkbox"/>
If so, explain _____												
57. Do you have or have you had Immune System Disorders (including AIDS, HIV, ARC)?											<input type="checkbox"/>	<input type="checkbox"/>
58. Have you ever taken penicillin?											<input type="checkbox"/>	<input type="checkbox"/>
59. WOMEN: Are you pregnant?											<input type="checkbox"/>	<input type="checkbox"/>

ARE YOU TAKING ANY OF THE FOLLOWING?

YES		NO		YES		NO		YES		NO	
60. Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	65. Tranquilizers	<input type="checkbox"/>	<input type="checkbox"/>	70. Allergy medication	<input type="checkbox"/>	<input type="checkbox"/>			
61. Blood thinners (Coumadin, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	66. Insulin/other diabetes medication	<input type="checkbox"/>	<input type="checkbox"/>	71. Nitroglycerin	<input type="checkbox"/>	<input type="checkbox"/>			
62. Blood pressure medication	<input type="checkbox"/>	<input type="checkbox"/>	67. Recreational drugs	<input type="checkbox"/>	<input type="checkbox"/>	72. Aspirin	<input type="checkbox"/>	<input type="checkbox"/>			
63. Thyroid medication	<input type="checkbox"/>	<input type="checkbox"/>	68. Heart medication	<input type="checkbox"/>	<input type="checkbox"/>	73. Other medication	<input type="checkbox"/>	<input type="checkbox"/>			
64. Birth control or hormone medication	<input type="checkbox"/>	<input type="checkbox"/>	69. Cortisone/steroids	<input type="checkbox"/>	<input type="checkbox"/>	If so, explain _____					

ARE YOU ALLERGIC TO HAVE YOU EXPERIENCED ANY ADVERSE REACTION TO THE ANY OF THE FOLLOWING?

YES		NO		YES		NO	
74. Barbiturates, sedatives or sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>	78. Novocaine (or other local anesthetics)	<input type="checkbox"/>	<input type="checkbox"/>		
75. Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	79. Penicillin	<input type="checkbox"/>	<input type="checkbox"/>		
76. Codeine or other narcotics	<input type="checkbox"/>	<input type="checkbox"/>	80. Erythromycin	<input type="checkbox"/>	<input type="checkbox"/>		
77. Any other medications	<input type="checkbox"/>	<input type="checkbox"/>	81. Other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>		

To the best of my knowledge, all of the preceding answers are true and correct.

Signature _____

Date _____

Patient Parent Guardian