HEALTH HISTORY

DATE: ____________

PATIENT'S NAME:______________________________ BIRTH DATE: ____________

YES NO Have you been hospitalized or had a serious illness in the last three years?
If yes, please describe: ______________________________

YES NO Are you currently being treated by a physician? Why? ______________________________

Date of your last medical exam? ______________________________

II. DO YOU HAVE OR HAVE YOU EVER HAD:

YES	NO	Heart disease or heart attack	YES	NO	Chest pain (angina)
YES	NO	Heart murmur or heart defect	YES	NO	Prosthetic heart valve
YES	NO	Rheumatic fever or Scarlet fever	YES	NO	Stroke
YES	NO	High blood pressure	YES	NO	Pacemaker
YES	NO	Persistent cough or coughing up blood	YES	NO	Asthma
YES	NO	TB, emphysema or other lung disease	YES	NO	Dry mouth
YES	NO	Dizziness or fainting spells	YES	NO	Seizures
YES	NO	Bleeding problems or bruise easily	YES	NO	AIDS/HIV
YES	NO	Artificial joint replacement	YES	NO	Tumors or cancer
YES	NO	Arthritis or rheumatism	YES	NO	Herpes or cold sores
YES	NO	Hepatitis type: A B C	YES	NO	Anemia
YES	NO	Parkinson's or Alzheimer's	YES	NO	Diabetes
YES	NO	Osteoporosis or osteopenia	YES	NO	Sinus problems
YES	NO	Depression or psychiatric care	YES	NO	Frequent headaches
YES	NO	Radiation therapy or chemotherapy	YES	NO	Migraine headaches
YES	NO	Family history of diabetes, heart problems, tumors	YES	NO	Other liver disease
YES	NO	Have you ever been diagnosed with Sjogren's Syndrome?			

III. ARE YOU TAKING OR DO YOU USE:

YES NO Tobacco in any form — YES NO Aspirin or blood thinners

YES NO Medication for weak bones

List prescription medications you take: ______________________________

List the over-the-counter or natural products you take: ______________________________

IV. WHAT ALLERGIES DO YOU HAVE?

YES	NO	Antibiotics (Penicillin, Erythromycin, Sulfa, etc.)	YES	NO	Codeine or Morphine
YES	NO	Barbiturates	YES	NO	Metals
YES	NO	Latex	YES	NO	Anesthetics

Other: ______________________________

V. WOMEN ONLY

YES NO Do you take birth control medication? — YES NO Are you breast feeding?

YES NO Are you pregnant?

VI. ALL PATIENTS

YES NO Do you have or have you had any other diseases or medical problems NOT listed on this form? ____________
If so, please describe: ______________________________

VII. NAME OF PHYSICIAN______________________ DATE LAST VISIT ______ PHONE ____________

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes in my health history and/or medications.

PATIENT SIGNATURE X______________________________ **DATE:** ____________

Change? ***Recall review (if changes, see back of form)***

YES NO PATIENT SIGNATURE: ______________________ **DATE:** _____

YES NO PATIENT SIGNATURE: ______________________ **DATE:** _____

JOHNSON
FAMILY DENTAL

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