CONFIDENTIAL HEALTH HISTORY

Patient	Name:			Date of Birth:		
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. CIR 1.	CLE APPRO Yes / No	OPRIATE ANSWER (Leave blan Is your general health good?	k if you do no	t understand the question)		
1.	103/110					
2	Vac / Na	If NO, explain:				
2.	Yes / No	Has there been a change in your h		•		
		If YES, explain:				
3.	Yes / No	Have you gone to the hospital or	emergency roo	om or had a serious illness in the last t	three years?	
		If YES, explain:				
4.	Yes / No	Are you being treated by a physic	ian now? If Y	ES, explain:		
		Date of last medical exam?		Reason for exam:		
5.	Yes / No	Have you had problems with prio				
				Name of last treating dentist:		
	M /NI.			Name of last treating dentist.		
6.	Yes / No	Are you in pain now?				
		If YES, explain:				
I. HA	VE EVER Y	YOU EXPERIENCED ANY OF T	HE FOLLOV	VING? (Please circle Yes or No for	each)	
	Yes / No	Chest pain (angina)	Yes / No	Blood in stools	Yes / No	Frequent vomiting
	Yes / No	Fainting spells	Yes / No	Diarrhea or constipation	Yes / No	Jaundice
	Yes / No	Recent significant weight loss	Yes / No	Frequent urination	Yes / No	Dry mouth
	Yes / No	Fever	Yes / No	Difficulty urinating	Yes / No	Excessive thirst
	Yes / No	Night sweats	Yes / No	Ringing in ears	Yes / No	Difficulty swallowing
	Yes / No	Persistent cough	Yes / No	Headaches	Yes / No	Swollen ankles
	Yes / No	Coughing up blood	Yes / No	Dizziness	Yes / No	Joint pain or stiffness
	Yes / No	Bleeding problems	Yes / No	Blurred vision	Yes / No	Shortness of breath
	Yes / No	Blood in urine	Yes / No	Bruise easily	Yes / No	Sinus problems
	Other:					
П. НА	AVE YOU E	EVER HAD OR DO YOU HAVE A	ANY OF THE	E FOLLOWING? (Please circle Yes	s or No for ea	ich)
	Yes / No	Heart disease	Yes / No	AIDS/HIV	Yes / No	Psychiatric care
	Yes / No	Family history of heart disease	Yes / No	Surgeries	Yes / No	Osteoporosis
	Yes / No	Heart attack	Yes / No	Hospitalization	Yes / No	Thyroid disease
	Yes / No	Artificial joint	Yes / No	Diabetes	Yes / No	Asthma
	Yes / No	Stomach problems or ulcers	Yes / No	Family history of diabetes	Yes / No	Hepatitis
	Yes / No	Heart defects	Yes / No	Tumors or cancer	Yes / No	Sexual transmitted diseas
	Yes / No	Heart murmurs	Yes / No	Chemotherapy	Yes / No	Herpes
	Yes / No	Rheumatic fever	Yes / No	Radiation	Yes / No	Canker or cold sores
	Yes / No	Skin disease	Yes / No	Arthritis, rheumatism	Yes / No	Anemia
	Yes / No	Hardening of arteries	Yes / No	Emphysema or other lung disease	Yes / No	Liver disease
	Yes / No	High blood pressure	Yes / No	Kidney or bladder disease	Yes / No	Eye disease
	Yes / No	Seizures	Yes / No	Stroke	Yes / No	Transplants
	Yes / No	Cosmetic surgery	Yes / No	Eating disorders	Yes / No	Tuberculosis
	Other:					
V. AF	RE YOU AL	LERGIC TO OR HAVE YOU HA	AD A REACT	TION TO ANY OF THE FOLLOW	ING? (Pleas	se circle Yes or No for each
	Yes / No	Aspirin	Yes / No	Valium or other sedatives	Yes / No	Codeine or other narcotic
	Yes / No	Penicillin or other antibiotics	Yes / No	Latex	Yes / No	Food
	Yes / No	Nitrous oxide	Yes / No	Local anesthetic	Yes / No	Metal
			1 55 / 110		100/110	
	Others:					

Yes / No Are you nursing? Yes / No Are you taking bin VII. ALL PATIENTS (Please circle Ye Yes / No Do you have or hav If YES, please expl Yes / No Have you ever been Yes / No Is there any issue of The practice of dentistry involves treating situation, medical consultation may be new If authorize the dentist to contact my physical au	remedicines ications dications: Ges or No for each) d you be pregnant? g? birth control pills? Yes or No for each have you had any of each pre-medicated if ken Fen-Phen? If Y he or condition that ang the whole perso needed prior to con visician.	or If YES, when the dental tree of the dental tree	eatment? If YES, why: I like to discuss with the dentist determines that there may to of dental treatment.	sted on this form? Atist in private? The bear potentially medically medically.	
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