Name____Date______________________________

HOSPITALIZATIONS AND SURGERIES

Year	*Hospital*	*Reason for hospitalization and outcome*

CHILDBIRTH HISTORY

Year of birth	*Sex*	*Complications, if any*

SERIOUS INJURIES, FRACTURES OR OTHER ILLNESSES

Event or illness	**Date**	**Outcome**

DENTAL HISTORY

Extractions no yes teeth numbers	Do you currently or did you have:
Bridges no yes (upper lower)	overbite underbite crooked teeth buck teeth
Does any bridge cross the midline? no yes	Orthodontia no yes, age
Root canals no yes	Reason for orthodontia:
Dentures upper lower partial Age last fit	Temporomandibular Joint (TMJ):
Implants no yes	splints no yes (upper lower)
	surgery no yes (left right)
	disc implants no yes (material=)

Medications (include dosage amount and frequency)	*ALLERGIES: to medications or substances*
Pharmacy **Name**_________________________**Phone**______________	

Name____Date__________________________

FAMILY HISTORY **Fill in health information about your family**				
Relation	*Age*	*State of health*	*Age at death*	*Cause of death*
Father				
Mother				
Brothers				
Sisters				

Please (√) If your blood relatives have had:		
	Disease	*Relationship*
	Arthritis, Gout	
	Asthma, Hay Fever	
	Cancer	
	Chemical Dependency	
	Diabetes	
	Heart Disease, Strokes	
	High Blood Pressure	
	Kidney Disease	
	Tuberculosis	
	Other	
	Other	

HEALTH HABITS Check (√) which substances you use and describe how much you use		
	Caffeine	
	Tobacco	
	Drugs	
	Water	
	Alcohol	
	Chocolate	
	Sugar	
	Other	

OCCUPATIONAL CONCERNS Check (√) if your work exposes you to the following:	
	Stress
	Hazardous Substances
	Heavy Lifting
	Other

EXERCISE	
Type	Frequency

Your Occupation____

Have you ever had a blood transfusion? No Yes (please give approximate dates__________________)

x_______________________________________ _________________

Patient and/or guardian signature Date