CONFIDENTIAL HEALTH HISTORY

Patient Name: _____ Date of Birth: _____

I. CIRCLE THE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. How would you rate your general health? (poor) 1 2 3 4 5 6 7 8 9 10 (excellent)
2. YES / NO Has there been a change in your health within the past year?
   If YES, explain: _____
3. YES / NO Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain: _____
4. YES / NO Have you had any surgeries?
   If YES, explain: _____
5. YES / NO Are you being treated by a physician now? If YES, explain: _____
   Date of last medical exam?_____ Reason for exam:_____
6. YES / NO Have you had problems with prior dental treatment?
   If YES, explain: _____
   Date of last dental exam: _____ Name of last treating dentist: _____
7. YES / NO Are you in pain now?
   If YES, explain: _____

II. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (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 Back problems	YES / NO Difficulty swallowing
YES / NO Frequent neck pain	YES / NO Ringing in ears	YES / NO Swollen ankles
YES / NO Persistent cough	YES / NO Headaches frequent/severe	YES / NO Joint pain or stiffness
YES / NO Coughing up blood	YES / NO Dizziness	YES / NO Shortness of breath
YES / NO Bleeding problems	YES / NO Blurred vision	YES / NO Sinus problems
YES / NO Blood in urine	YES / NO Bruise easily	YES / NO Jaw problems
YES / NO Excessive nervousness	YES / NO Difficulty breathing	

III. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO THE FOLLOWING? (Please circle Yes or No for each)

YES / NO Aspirin	YES / NO Valium	YES / NO Tetracycline
YES / NO Darvon	YES / NO Demerol	YES / NO Vicodin
YES / NO Codeine	YES / NO Penicillin	YES / NO Percodan
YES / NO Latex	YES / NO Food	YES / NO Nitrous oxide
YES / NO Dental anesthetic	YES / NO Erythromycin	YES / NO Metal

Others: _____