

Health History Form

Patient's Name _____ Date of Birth ____/____/____

Gender: _____ Height: _____ Weight: _____

Your medical history is important to the treatment you will receive. Therefore, it is important that you respond to each question honestly and completely. Please circle your responses.

Please describe your current health: Excellent Good Fair Poor

Please describe the symptoms you are currently having today: _____

Have there been any changes in your general health in the past year? Yes No

If yes, please describe: _____

Are you now under a doctor's care for a particular problem at this time? Yes No

If yes, why? _____ Date of last physical exam ____/____/____

Have you ever been hospitalized or had a serious illness? Yes No

If yes, why? _____

Have you ever had surgery? Yes No

If yes, when and what for? Date of surgery: _____ Reason for surgery: _____

Date of surgery: _____ Reason for surgery: _____

PATIENT MEDICAL HISTORY

Do you have or have you ever had:

Congenital heart disease, cardiovascular disease (heart attack, heart murmur, coronary artery disease, chest pain, high/ low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker)?	Yes	No	Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)?	Yes	No
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Implants placed anywhere in the body (heart valve, pacemaker, hip, knee)?	Yes	No	Bleeding disorder, anemia, bleeding tendency, blood transfusion? Do you bruise easily?	Yes	No
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Kidney disease or kidney failure, requiring dialysis?	Yes	No	Liver disease (jaundice, hepatitis A, B, or C)?	Yes	No
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Thyroid disease?	Yes	No	Arthritis?	Yes	No
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Stomach ulcers or colitis?	Yes	No	Significant weight loss or gain?	Yes	No
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Clicking, popping, or pain within the jaw joint and/or difficulty opening mouth?	Yes	No	Seizures, convulsions, epilepsy, fainting or dizziness?	Yes	No
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Frequent or recurring mouth sores?	Yes	No	Sinus or nasal problems?	Yes	No
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Glaucoma?	Yes	No	Sleep apnea?	Yes	No
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Diabetes?	Yes	No	Osteoporosis or osteopenia?	Yes	No
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Any cancer, radiation, or chemotherapy? Yes No

Describe: _____ Date of your last treatment? _____

Do you have any other disease, condition or problem not listed above that you think the doctor should know about? Yes No

If yes, please explain: _____

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SOCIAL HISTORY

Have you ever smoked, vaped or chewed tobacco? Yes No If yes, for how long? _____

Have you ever sought professional care or been hospitalized for:

Substance abuse? Yes No

Emotional disorders? Yes No

Alcoholism? Yes No

Do you use:

Alcohol? Yes No How often? _____

Marijuana? Yes No How often? _____

Recreational drugs? Yes No How often? _____

DENTAL HISTORY

Have you had any adverse effects from dental treatment? Yes No If Yes, please explain? _____

Do you wish to talk to the doctor privately about anything? Yes No

**I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible.
To the best of my knowledge, the above information is complete and correct.**

Signature of patient, parent, guardian

Date

Printed name of patient, parent, guardian/Relationship

Doctor's Signature

HEALTH HISTORY UPDATE

Date Comments Doctor's Signature
