

NEW PATIENT HEALTH HISTORY FORM
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Name _____ Date _____ Age _____

Date of birth _____ Social Security # _____

Address _____ Town _____ Zip _____

Referring Dentist & Number _____ Date of last visit _____

Physician & Number _____ Date of last visit _____

Please respond by circling YES or NO to the questions that follow:

- | | |
|---|--------|
| 1. Have you ever had hives after taking medication | NO YES |
| 2. Are you allergic to any medication that you know of | NO YES |
| 3. Does any medication make you physically ill, nauseated, sick | NO YES |
| 4. Have you ever had hepatitis (A,B,C other) | NO YES |
| 5. Have you ever been denied permission to give blood as a donor | NO YES |
| 6. Have you had any recent extended hospital stays | NO YES |
| 7. Have you been told you have a heart murmur | NO YES |
| 8. Have you been told you needed to take antibiotics for dental visits
Because of the murmur | NO YES |
| 9. Have you had a stroke or CVA | NO YES |
| 10. Have you ever had Rheumatic Fever | NO YES |
| 11. Have you been diagnosed with high or low blood pressure(circle which) | NO YES |
| 12. Have you been diagnosed as being anemic | NO YES |
| 13. Have you ever had tuberculosis or lived with anyone who did | NO YES |
| 14. Have you ever been diagnosed as epileptic or experienced seizures | NO YES |
| 15. Are you prone to fainting | NO YES |
| 16. Do you have any sexually transmitted diseases | NO YES |
| 17. Do you have AIDS suspect you have AIDS or are HIV+ | NO YES |
| 18. Have you had radiation therapy for a disease | NO YES |
| 19. Do you ever have cold sores or fever blisters on your lips | NO YES |
| 20. Do you ever have aphthous ulcers (cankor sores) in your mouth | NO YES |
| 21. Do you have nose bleeds often or have you been diagnosed with a
Bleeding disorder | NO YES |
| 22. Are you ever short of breath climbing a flight of stairs | NO YES |
| 23. Do you get chest pain or experience angina after mild exercise | NO YES |
| 24. Do you feel you suffer from palpitations or fast heart beat | NO YES |

25. Are you taking or have you taken any medication regularly in the Past 3 weeks. NO YES
26. What is the medication(s) _____
27. Have you had any injections in the last 6 months NO YES
28. Have you had to have cortisone treatments in the last year NO YES
29. Are you troubled by nervousness, tension or emotional problems NO YES
30. Have you been diagnosed with diabetes, and if so which type NIDDM or IDDM NO YES
31. Are you asthmatic or suffer from hay fever (circle one) NO YES
32. Do you take aspirin every day or every other day NO YES
33. Do you smoke presently and if so how much in terms of pack per day NO YES
34. Did you smoke, how much _____ and when did you quit _____ NO YES
35. Have you been diagnosed with thyroid problems NO YES
36. Have you been seen by a physician in the last year NO YES
37. Have you had a MI, myocardial infection, heart attack within the last 6 months NO YES
38. Are you being treated for osteoporosis. What medication _____

FOR WOMEN ONLY

39. Are you taking oral contraceptives NO YES
40. Are you pregnant NO YES
41. Have you had any significant bleeding associated w/menses NO YES

FOR ALL

Please state any other aspect of your medical history that you feel is important, including history, medication, timing, or complexity as it might pertain to periodontal/dental/surgical therapy

For CONVERSATION

How many children do you have _____ what ages _____
 What is your occupation _____

FOR CHILDREN ONLY

I authorize examination and treatment of my child _____ (print child's name, age, date of birth)

Date _____ Signature of Parent or Guardian _____

Date _____ Your Signature _____

FILL OUT AND PLEASE BRING WITH YOU TO INITIAL CONSULTATION