



CONFIDENTIAL HEALTH HISTORY

Name:	Date:
--------------	--------------

I. Please Answer the Following Questions

Your current health is Good Fair Poor Please Explain:

Physician's Name: _____ Phone: _____ City: _____

Date and nature of last visit: _____ Date of last physical exam: _____

Are you being treated by a physician now? Y N Please Explain:

Has there been any change in your health within the last year? Y N Please Explain:

Have you gone to the hospital/ emergency room or had a serious illness in the last three years? Y N Please Explain:

Are you taking any Prescription/Over the Counter Drugs or Herbal supplements? Y N Please List:

Do you have any Drug Allergies? Y N Please List:

II. Please check if you have or had any of the following

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Cough, persistent | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> AIDS/HIV positive | <input type="checkbox"/> Cough up blood | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Restricted/Special Diet |
| <input type="checkbox"/> Alcohol/Drug Abuse | <input type="checkbox"/> Dental Anxiety | <input type="checkbox"/> Herpes | <input type="checkbox"/> Rheumatic/Scarlet Fever |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Ringing in the ear (Tinnitus) |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Difficult Breathing | <input type="checkbox"/> Hospitalized | <input type="checkbox"/> Sensitive Teeth |
| <input type="checkbox"/> Arthritis/ Rheumatism | <input type="checkbox"/> Difficulty chewing | <input type="checkbox"/> Implants | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Artificial Bones/Joints | <input type="checkbox"/> Difficulty Swallowing (Dysphasia) | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Artificial Heart valve | <input type="checkbox"/> Discomfort with TMJ | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Dry Mouth | <input type="checkbox"/> Latex Sensitivity | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Back/Postural problems | <input type="checkbox"/> Ear congestion | <input type="checkbox"/> Loose Teeth | <input type="checkbox"/> Skin Disease/Rash |
| <input type="checkbox"/> Bacterial Infections/MRSA | <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Bell's Palsy | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Material/Food Allergies | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Eye Disease | <input type="checkbox"/> Metal Rods/Pins | <input type="checkbox"/> Swelling of feet or ankles |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Facial or Jaw Pain | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Nervous/Anxious | <input type="checkbox"/> Tingling of Fingertips |
| <input type="checkbox"/> Cancer/Chemotherapy | <input type="checkbox"/> Fever/Cold Blisters | <input type="checkbox"/> Old or broken fillings | <input type="checkbox"/> Tobacco Habit (smoke/chew) |
| <input type="checkbox"/> Cervical Pain | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chest Pain (Angina) | <input type="checkbox"/> Food Allergies | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Previous gum treatment | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Clenching or Grinding | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Problems with previous dental work | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Colitis/Ulcer | <input type="checkbox"/> Head, neck, shoulder aches | <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Vertigo (Dizziness) |
| <input type="checkbox"/> Cosmetic Surgery | <input type="checkbox"/> Heart Attack/Surgery | <input type="checkbox"/> Rapid weight loss/gain | <input type="checkbox"/> Worn and/or discolored teeth |
| <input type="checkbox"/> Cortisone treatments | <input type="checkbox"/> Heart Disease/Defect | <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Other |

Do you have or had any other diseases or medical problems not listed on this form? Y N Please Explain:

