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HEALTH HISTORY

Patient Name _____ Birth date _____ Sex _____ Age _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Primary Care Physician _____ Address _____ Phone _____

		YES	NO
1.	Are you in good health now?	☐	☐
2.	Are you now under the care of a physician or specialist?	☐	☐
	If so, what is the condition being treated? _____		
3.	Have you ever been hospitalized or had a serious illness?	☐	☐
	If yes, explain _____		

4.	**Are you ALLERGIC to or have you experienced any reaction to the following?**	YES	NO
	Local anesthetics (e.g. novocaine)	☐	☐
	Codeine	☐	☐
	Aspirin	☐	☐
	Penicillin/other antibiotics	☐	☐
	Sulfa drugs	☐	☐
	Latex	☐	☐
	Barbiturates/sedatives/sleeping pills	☐	☐

Other allergies:

_____

_____

5.	**Are you taking any of the following medications?**	YES	NO
	Antibiotics/sulfa drugs	☐	☐
	Blood thinners	☐	☐
	Blood pressure medication	☐	☐
	Thyroid medicine	☐	☐
	Cortisone/steroids	☐	☐
	Antihistamines/allergy drugs/cold remedies	☐	☐
	Tranquilizers	☐	☐
	Insulin/other diabetes drugs	☐	☐
	Recreational drugs	☐	☐
	Digitalis/other heart medications	☐	☐
	Nitroglycerin	☐	☐
	Aspirin	☐	☐

6. **List all medications you are currently taking:**

Medication and dosage:	Reason for taking:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

7. **Do you have or have you ever had any of the following?**

HEART/BLOOD VESSELS	**YES**	**NO**
High blood pressure	☐	☐
Mitral valve prolapse	☐	☐
Artificial heart valve	☐	☐
Pacemaker	☐	☐
Heart surgery	☐	☐
Heart attack/trouble	☐	☐
Congenital heart disease	☐	☐
Rheumatic fever	☐	☐
Heart murmur	☐	☐
Chest pain/discomfort	☐	☐
Shortness of breath	☐	☐
Swelling of ankles	☐	☐
Other	☐	☐

ENDOCRINE	**YES**	**NO**
Diabetes	☐	☐
Family history of diabetes	☐	☐
Thyroid condition/goiter	☐	☐
Other	☐	☐

TMJ	**YES**	**NO**
Clicking/popping of jaw	☐	☐
Difficulty opening/closing jaw	☐	☐
Clenching/grinding teeth	☐	☐
Shifting of teeth	☐	☐
Change in bite	☐	☐
Muscle soreness (jaw)	☐	☐
Frequent headaches when you wake up	☐	☐

RESPIRATORY	**YES**	**NO**
Tuberculosis	☐	☐
Emphysema	☐	☐
Asthma/hay fever	☐	☐
Sleep apnea….	☐	☐
Snoring	☐	☐
Difficulty breathing while lying down	☐	☐
Other	☐	☐

NERVOUS SYSTEM	**YES**	**NO**
Stroke	☐	☐
Headaches	☐	☐
Convulsions/epilepsy	☐	☐
Numbness/tingling	☐	☐
Dizziness/fainting	☐	☐
Psychiatric treatment	☐	☐
Other	☐	☐

BONE/MUSCLES	**YES**	**NO**
Arthritis/rheumatism	☐	☐
Artificial joints/limbs	☐	☐
Other	☐	☐

THROAT	**YES**	**NO**
Soreness/hoarseness	☐	☐

NOSE	**YES**	**NO**
Frequent nosebleeds	☐	☐
Sinus problems	☐	☐

DIGESTIVE SYSTEM	**YES**	**NO**
Hepatitis	☐	☐
Jaundice	☐	☐
Ulcers	☐	☐
Change in appetite	☐	☐

BLOOD	**YES**	**NO**
Bruise easily	☐	☐
Anemia	☐	☐
Blood transfusion	☐	☐

URINARY	**YES**	**NO**
Kidney disease	☐	☐
Venereal disease	☐	☐

OTHER	**YES**	**NO**
Organ replacement	☐	☐
Radiation therapy	☐	☐
Chemotherapy	☐	☐
Tumors or growths	☐	☐
Cancer	☐	☐
HIV/AIDS	☐	☐
Tobacco use (any form)	☐	☐
Alcohol use	☐	☐
Recreational drug use	☐	☐
Are you currently pregnant?	☐	☐

If yes, due date: _____

8. Is there any disease, condition or problem not listed above that you think we should be aware of? If so, explain:

_____

_____

_____

_____

To the best of my knowledge, all of the preceding answers are true and correct.
If I ever have any change in my health or change in my medication, I will inform Dr. Semans at my next appointment. I hereby consent to all dental treatments as indicated by Dr. Semans in accordance with sound and prudent dental practice.

Signature of Patient,
Parent or Guardian _____ Date _____