

HEALTH HISTORY

Patient Name _____ Today's Date _____
Age _____ Birthdate _____ Date of last full body examination _____

1. When exposed to sun do you
 Always Burn, Never Tan
 Usually Burn, Difficult Tan
 Sometimes Burn, Average Tan
 Rare Burn, Tan With Ease
 Very Rarely Burn, Tan Very Easily
 No Burn, Tan Very Easily
2. Do you drink alcohol?
 Yes No
3. Do you use IV drugs?
 Yes No
4. Do you use illegal drugs?
 Yes No
5. Do you smoke?
 Yes No
6. Have you ever had skin cancer?
 Yes No
If yes, what type? _____
7. Has anyone in your family had skin cancer?
 Yes No
If yes, who? _____
What type? _____
8. Do you have a history of any specific skin diseases?
 Yes No
If yes, please list: _____

9. Do you bleed easily?
 Yes No
10. Have you ever been exposed to or have HIV (AIDS)?
 Yes No
11. Do you have artificial joints?
 Yes No
Where? _____
If yes, Do you require pre-op antibiotics prior to dental procedures?
 Yes No

12. Have you ever had dental anesthesia?
 Yes No
13. Have you ever had an allergic reaction to dental anesthesia (Novocain)?
 Yes No
14. (Women) Are you pregnant?
 Yes No
15. What is your occupation? _____

16. List any surgical procedures you have had with the date that they were performed:

17. List any other disease or condition we should know about: _____

18. Any environmental/special allergies:

Continued on the
back!!



19. **Conditions** (Check symptoms you currently have or had in the past):

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Arthritis/ Joint Deformity | <input type="checkbox"/> Diabetes | <input type="checkbox"/> History of Cancer | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | If yes, what type?
_____ | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Epilepsy | _____ | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Fainting | _____ | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Bowel Problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Measles | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Multiple Sclerosis | |
| | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pacemaker | |

20. Medications You Are Currently Taking:

21. Medications You Are Allergic To:

Pharmacy Name: _____
Phone: _____

Completed By:
 Patient
 Medical Assistant _____ (Initials)