

# HEALTH HISTORY

Patient's Name \_\_\_\_\_

1. Are you being treated for any condition by a physician now?	Yes	No	8. Do you have AIDS or have you ever tested positive for the AIDS (HIV) Virus?	Yes	No
2. Have you ever experienced a bad reaction to a dental anesthetic?	Yes	No	9. Have you ever experienced a bad reaction to any of the following drugs?	Yes	No
3. Do you bleed for a long time when you cut yourself?	Yes	No	Aspirin . . . . .	Yes	No
4. Have you ever had surgery or X-ray treatment for a tumor, growth or other condition in your mouth or on your lips?	Yes	No	Penicillin . . . . .	Yes	No
5. Are you taking any medicines now?	Yes	No	Iodine . . . . .	Yes	No
6. Have you been examined by your physician within the last year?	Yes	No	Sulfonamides (sulfa) . . . . .	Yes	No
7. Have you had any of the following:			Barbiturates (sleeping pills) . . . . .	Yes	No
Rheumatic Fever . . . . .	Yes	No	Other Medicines . . . . .	Yes	No
Inflammatory Rheumatism . . . . .	Yes	No	10. Do you have any sensitive teeth?	Yes	No
Jaundice (hepatitis) . . . . .	Yes	No	11. Have you had a toothache recently?	Yes	No
Diabetes (sugar disease) . . . . .	Yes	No	12. Do you have bleeding gums?	Yes	No
High Blood Pressure . . . . .	Yes	No	13. Is it difficult for you to open your mouth as wide as you would like?	Yes	No
Tuberculosis . . . . .	Yes	No	14. Does your jaw click when you chew?	Yes	No
Veneral Disease . . . . .	Yes	No	15. Do you ever have fits or convulsions?	Yes	No
Heart Attack . . . . .	Yes	No	16. Do you have a tendency to faint?	Yes	No
Stroke . . . . .	Yes	No	17. Do you have any blood disorder such as anemia (thin blood)?	Yes	No
Heart Murmur . . . . .	Yes	No	18. Are you excessively nervous?	Yes	No
Other Health Problems . . . . .	Yes	No	19. WOMEN - Are you pregnant at the present time?	Yes	No

## HEALTH UPDATE:

Date: year \_\_\_\_\_ / month \_\_\_\_\_ / day \_\_\_\_\_

Patient's Signature \_\_\_\_\_