S E O N H O H A P R O S T H O D O N T I C S

Patient Health History

Patient Name: ____________________ Soc. Sec. No.: ____________________

Birthdate: ____________________

Please check the appropriate answer (Leave blank if you do not understand the question).

I. GENERAL HEALTH:

	Yes	No	
1.	❑	❑	Is your general health good?
2.	❑	❑	Has there been a change in your health within the last year?
3.	❑	❑	Have you been hospitalized or had a serious illness in the last three years? If yes, please explain: ____________________
4.	❑	❑	Are you being treated by a physician now? For what? ____________________ Date of last medical exam: ____________ Date of last dental appt.: ____________
5.	❑	❑	Have you had problems with prior dental treatment?
6.	❑	❑	Are you in pain now?

II. DO YOU FREQUENTLY EXPERIENCE:

	Yes	No			Yes	No	
7.	❑	❑	Chest pain (angina)?	18.	❑	❑	Dizziness?
8.	❑	❑	Swollen ankles?	19.	❑	❑	Ringing in the ears?
9.	❑	❑	Shortness of breath?	20.	❑	❑	Headaches?
10.	❑	❑	Recent weight loss, fever, and/or night sweats?	21.	❑	❑	Fainting spells?
11.	❑	❑	Persistent cough and/or coughing up blood?	22.	❑	❑	Blurred vision?
12.	❑	❑	Bleeding problems and/or bruising easily?	23.	❑	❑	Seizures?
13.	❑	❑	Sinus problems?	24.	❑	❑	Excessive thirst?
14.	❑	❑	Difficulty swallowing?	25.	❑	❑	Frequent urination?
15.	❑	❑	Diarrhea, constipation, and/or blood in stools?	26.	❑	❑	Dry mouth?
16.	❑	❑	Frequent vomiting and/or nausea?	27.	❑	❑	Jaundice?
17.	❑	❑	Difficulty urinating and/or blood in urine?	28.	❑	❑	Joint paint and/or stiffness?

III. DO YOU HAVE OR HAVE YOU HAD:

	Yes	No					
29.	❑	❑	Heart disease?	40.	❑	❑	AIDS or ARC?
30.	❑	❑	Heart attack and/or heart defects?	41.	❑	❑	Tumors and/or cancer?
31.	❑	❑	Rheumatic fever?	42.	❑	❑	Arthritis rheumatism?
32.	❑	❑	Stroke, hardening of arteries?	43.	❑	❑	Eye disease?
33.	❑	❑	High blood pressure?	44.	❑	❑	Skin diseases?
34.	❑	❑	TB, emphysema, and/or other lung diseases?	45.	❑	❑	Anemia?
35.	❑	❑	Hepatitis and/or other liver disease?	46.	❑	❑	STD (i.e. syphilis or gonorrhea)?
36.	❑	❑	Stomach problems and/or ulcers?	47.	❑	❑	Herpes?
37.	❑	❑	Allergies to: drugs, foods, medication?	48.	❑	❑	HPV?
38.	❑	❑	Kidney and/or bladder disease?	49.	❑	❑	Thyroid and/or adrenal disease?
39.	❑	❑	Family history of diabetes, heart problems, and/or tumors?	50.	❑	❑	Diabetes?

IV. DO YOU HAVE OR HAVE YOU HAD:

	Yes	No			Yes	No	
51.	❑	❑	Psychiatric care?	56.	❑	❑	Hospitalization?
52.	❑	❑	Radiation treatments?	57.	❑	❑	Blood transfusions?
53.	❑	❑	Chemotherapy?	58.	❑	❑	Surgeries?
54.	❑	❑	Prosthetic heart valve?	59.	❑	❑	Pacemaker?
55.	❑	❑	Artificial joint?				

V. ARE YOU CURRENTLY TAKING:

	Yes	No			Yes	No	
60.	❑	❑	Recreational drugs?	62.	❑	❑	Tobacco in any form?
61.	❑	❑	Medicinal drugs (Including aspirin)?	63.	❑	❑	Alcohol?

Please list: ____________________

VI. FEMALES ONLY:

64.	❑	❑	Are you or could you be pregnant or nursing?	65.	❑	❑	Are you taking birth control pills?

VII. ALL PATIENTS:

66. ❑ ❑ Do you have or have you had any other disease or medical problems NOT listed on this form?
If so, please explain: ____________________

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

____________________ Patient Signature

____________________ Date