Health History Questionnaire

All questions contained in this questionnaire are strictly confidential
and will become part of your medical records.

Name:		Today's Date:
DOB ___/___/_____	Male □ Female □	Date of last exam ___/___/_____

Personal Health History

(Some medical conditions may affect your oral health. Please answer the following questions to the best of your ability.)

Childhood illness: Measles □ Mumps □ Rubella □ Chickenpox □ Rheumatic Fever □ Polio □

Are you allergic, or had any adverse reaction to any of the following?	Antibiotics □ (please specify) _____ _____	Pain medication (please specify) _____ _____

Metals □ Latex □ Anesthetics □ Other (please list)

Please check any of the conditions you have had or may have now

□ Anemia	□ Asthma	□ Drug/Alcohol Abuse	□ Frequent Headaches
□ Angina (chest pain)	□ Cancer	□ Emphysema	□ Neck/Shoulder Pain
□ Artificial joints	□ Congenital Heart Def.	□ Epilepsy or Seizure	□ Glaucoma
□ Artificial Valves	□ Diabetes	□ Fainting Spells	□ Heart Attack/Stroke
□ Arthritis	□ Difficulty Breathing	□ Fever Blisters/Herpes	□ Heart Murmur
□ Heart Surgery	□ High Blood Pressure	□ Malignancies	□ Radiation Treatment
□ Hemophilia	□ Low Blood Pressure	□ Mitral Valve Prolapse	□ Rheumatic Fever
□ Hepatitis	□ HIV/Aids	□ Neurological Problem	□ Ulcers/ Colitis
□ STD	□ Thyroid Problems	□Tuberculosis	□ Chemotherapy

□ Other Please Specify

Are you taking any prescription drugs or herbal medications? (please list)

For Women:	Are you taking oral contraceptives □ Y □ N	Are you Pregnant □ Y □ N	Are you Nursing □ Y□ N

Have you ever been hospitalized for any reason?

When:	Reason
When:	Reason:

I understand that this information that I have given today is true and correct to the best of my knowledge, I also understand that this information will be held in strict confidence, and that it is my responsibility to inform this office of any change in my medical status.

Signature: Date:

For Official Use Only

Date	Updated Information	Initials	Date	Updated Information	Initials