Health History Form

Patients Name:_____ Birthdate_____Sex:____Age:____
Name of Physician:_____Phone#:_____Last Exam:_____
1. Have you been hospitalized or been under the care of a physician in the last five years? ___ YES___NO
2. Have you ever had Heart Disease? ---------- ___ YES ___NO
3. Have you ever had high blood pressure?---------- ___ YES ___NO
4 .Have you ever had Rheumatic Fever or been told you have or had a Heart Murmur? ___ YES___NO
5. Do you have a Pacemaker?---------- ___ YES___NO
6. Do you Faint, get short of breath or Fatigue easily on occasion?---------- ___ YES___NO
7. Do you ever get Chest Pain?---------- ___YES___NO
8. Do your ankles ever swell?---------- ___ YES___NO
9. Do you bruise easily or Bleed Abnormally after cuts, scratches or extractions? ___YES___NO
10. **Are you Presently taking Medication**? List:_____
_____
11. Have you ever had a reaction to aspirin, Penicillin, Codeine, local anesthesia or other medicines?
Which?_____ ___YES___NO
Allergic to any Medication and which?_____
12. Have you taken Steroids (Cortisone) in the past two years?---------- ___YES___NO
13. Have you ever been treated with radiation therapy for tumors or cancer? ---------- ___YES___NO
14. Do you Smoke? How much? _____ ___YES___NO
15. WOMEN ONLY ; Are you Pregnant?---------- ___YES___NO
Are you Nursing? ---------- ___YES___NO

16.CHECK if you have ever had any of the following Conditions:

__ANEMIA	__EMPHYSEMA	__THYROID DISEASE	__STROKE
__AIDS	__SICKLE CELL DISEASE	__STOMACH ULCERS	__HEART ATTACK
__ARTHRITIS	__HEPATITIS	__VENERAL DISEASE	__ANGINA
__BLOOD DISEASE	__EPILEPSY/SEIZURES	__TB(TUBERCULOSIS)	__CANCER
__SPLEEN PROBLEM	__LIVER DISEASE	__SCARLET FEVER	__DIABETES
__CHEMOTHERAPY	__ GLAUCOMA	__BLEEDING DISORDER	
__JOINT REPLACEMENTS		__ CHEST PAIN	

17. Do you have difficulty opening your mouth, or does your jaw “LOCK” or get stuck? __YES __NO
18. Have you previously been treated or diagnosed for Tempromandibular joint(TMJ)? __ YES__ NO
19. Have you ever had any injury to your jaw, neck or head? __YES__ NO

I understand that the above information is confidential, and certify that it is correct to the best of my Knowledge.

DATE:_____ PATIENT SIGNATURE:_____

DOCTOR’S SIGNATURE: _____