Encino Family Dental
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Confidential Health History Form

Date______________

Name____ Date of Birth_______________________

I. Please circle the appropriate answer.

Y N Is your general health good? If no, explain____
Y N Has there been a change in your health within the last year? If yes, explain______________________
Y N Have you gone to the hospital or emergency room or had a serious illness in the last three years?
If Yes, explain____
Y N Are you being treated by a physician now? If yes, explain_________________________________
Reason for exam____
Y N Have you had problems with prior dental treatment? If yes, explain___________________________
Date of last dental exam________________
Y N Are you in pain now? If yes, explain____

II. Have you ever experienced any of the following? (Please circle Y or N)

Y N Chest pain
Y N Fainting spells
Y N Recent significant weight loss/gain
Y N Fever
Y N Night sweats
Y N Persistent cough
Y N Coughing up blood
Y N Bleeding problems
Y N Blood in urine
Y N Blood in stools
Y N Diarrhea or constipation
Y N Frequent urination
Y N Difficult urinating
Y N Ringing in ears
Y N Headaches
Y N Dizziness
Y N Blurred vision
Y N Bruise easily
Y N Frequent Vomiting
Y N Jaundice
Y N Dry mouth
Y N Excessive thirst
Y N Difficult swallowing
Y N Swollen ankles
Y N Joint pain/stiffness
Y N Shortness of breath
Y N Sinus problems

III. Have you had or do you have any of the following? (Please circle Y or N)

Y N Heart disease
Y N Family history of heart disease
Y N Heart attack
Y N Artificial joints
Y N Stomach problems/ulcers
Y N Heart defects
Y N Sexually transmitted disease
Y N Rheumatic fever
Y N Skin disease
Y N Emphysema or other lung disease
Y N Kidney or bladder disease
Y N Stroke
Y N AIDS/HIV
Y N Treatment for emotion condition
Y N Drug addiction
Y N Pace maker
Y N Hospitalization
Y N Diabetes
Y N Family history of Diabetes
Y N Tumors or caner
Y N Chemotherapy
Y N Radiation
Y N Arthritis, rheumatism
Y N Liver disease
Y N Glaucoma
Y N Transplants
Y N Anxiety
Y N Eating disorders
Y N Osteoporosis
Y N Thyroid disease
Y N Asthma
Y N Hepatitis
Y N Heart Murmurs
Y N Herpes
Y N Canker or cold sores
Y N Anemia
Y N High blood pressure
Y N Seizures
Y N Tuberculosis
Y N Depression

IV. Are you allergic to or have you had a reaction to any of the following? (Please circle Y or N)

Y N Aspirin
Y N Penicillin
Y N Local Anesthetic
Y N Valium
Y N Percocet
Y N Erythromycin
Y N Tetracycline
Y N Latex
Y N Clindamycin
Y N Vicodin
Y N Nitrous oxide
Y N Other______________________
Y N Codeine
Y N Metal

V. Are you taking or have you taken any of the following in the last three months? (Please circle Y or N)

Y N Recreational drugs
Y N Over the counter medications
Y N Weight loss medications
Y N Corticosteroids
Y N Tobacco in any form
Y N Alcohol
Y N Bisphosphonates
Y N Antibiotics
Y N Supplements/Vitamins
Y N Aspirin

Please list medications you are currently taking, either over the counter or prescription____
____

VI. Women only (Please circle yes or no)

Y N Are you pregnant or could you be pregnant?

Y N Are you nursing?

Y N Are you taking oral contraceptives?

VII. All patients (Please circle Y or N)

Y N Do you have or have you had any other diseases or medical problems NOT listed on this form? If yes, explain.
Y N Have you ever been pre-medicated for dental treatment? If yes, why?____
Y N Have you ever taken Fen-Phen? If yes, when?____
Y N Is there any issue or condition that you would like to discuss with the dentist in private?

I certify that I have read and understand this form. 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. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of patient (parent/guardian)_________________________________ Date__________________________

Signature of Dentist____ Date__________________________