CHESTER DENTAL ASSOCIATES
HEALTH HISTORY

Patient Name:____ **Date of Birth:**______________

I. Circle Appropriate Answer:

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No **Have you been hospitalized** or had a serious illness in the last three years?
   IF YES, why?
4. Yes No Are you being treated by a physician now? For what?
   Date of last medical exam?______________ Date of last dental exam?______________
5. Yes No Have you had problems with prior dental treatment?
6. Yes No Have you reacted adversely to local anesthetics, penicillin, or other antibiotics/medications?
   Please explain:

II. Have You Experienced:

7. Yes No Chest pain (angina)?
8. Yes No Swollen ankles?
9. Yes No Shortness of breath?
10. Yes No Recent weight loss, fever, night sweats?
11. Yes No Persistent cough, coughing up blood?
12. Yes No Bleeding problems, bruising easily?
13. Yes No Frequent urination?
14. Yes No Difficulty swallowing?
15. Yes No Joint pain, stiffness?
16. Yes No Dizziness/headaches?
17. Yes No Ringing in ears?
18. Yes No Difficulty urinating?
19. Yes No Fainting spells?
20. Yes No Blurred vision?
21. Yes No Seizures?
22. Yes No Excessive thirst?
23. Yes No Sinus problems?
24. Yes No Jaundice?

III. Do you have, or have you had:

25. Yes No Heart disease?
26. Yes No Heart attack, heart defects?
27. **Yes No Heart murmers, mitral valve prolapse?**
28. Yes No Rheumatic fever?
29. Yes No Stroke, hardening of arteries?
30. Yes No High blood pressure?
31. Yes No Asthma, TB, other lung disease?
32. Yes No Hepatitis, other liver diseases?
33. Yes No Stomach problems, ulcers?
34. **Yes No Allergies to: drugs, medications, latex?**
   Please list:
35. Yes No Diabetes, heart problems in family?
36. Yes No Psychiatric care?
37. Yes No Radiation treatments/chemotherapy?
38. Yes No Artificial joints such as hip/knee replacement?
39. **Yes No Prosthetic heart valve/stents?**
40. Yes No Thyroid/adrenal disease?
41. Yes No Diabetes?
42. Yes No Kidney/bladder disease?
43. Yes No Dry mouth?
44. Yes No Herpes?
45. Yes No Anemia?
46. Yes No Skin diseases?
47. Yes No Eye diseases?
48. Yes No Arthritis, rheumatism?
49. Yes No Cancer, tumors?
50. Yes No AIDS/HIV?
51. Yes No Pacemaker?
52. Yes No Blood transfusions?
53. Yes No Surgeries?
54. Yes No Contact lenses?

IV. Are you taking:

55. Yes No Tobacco/alcohol?
56. Yes No Drugs, medications, over-the-counter medicines?
   Please list:
57. Yes No Have you taken blood thinners in the past 30 days?

V. Women only:

58. Yes No Are you or could you be pregnant or nursing?
59. Yes No Taking birth control pills?

VI. All patients:

60. Yes No Do you have or have you had other diseases or medical problems NOT listed on this form?

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

Patient Signature:____ **Date:**______________

(OFFICE USE ONLY)

DATE:____________ **MEDICAL/MEDICATION CHANGES: Y / N**

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Patient Signature____

DATE:____________ **MEDICAL/MEDICATION CHANGES: Y / N**

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Patient Signature____

DATE:____________ **MEDICAL/MEDICATION CHANGES: Y / N**

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DATE:___________ MEDICAL/MEDICATION CHANGES: Y / N

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