

PLACE PATIENT LABEL HERE

Original Date:
Dates Revised:

HEALTH HISTORY QUESTIONNAIRE

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

Name				DOB			
Please check the following YES or NO : <i>(conditions you have or have had in the past)</i>							
Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Heart Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Lung Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Heart Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Bronchitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Heart Valve Problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
High or Low Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No		HIV or AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Convulsive Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Liver Disease/Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No					
Joint replaced? _____				When? _____			
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Chemotherapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When? _____	
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, Type I or Type II		Insulin	<input type="checkbox"/> Yes	<input type="checkbox"/> No
				Oral Med	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Has your medical doctor ever told you that you need to be pre-medicated with an antibiotic prior to dental treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Environmental allergies: <input type="checkbox"/> Yes <input type="checkbox"/> No List: Allergic to: Latex Metals Dyes Tape Solutions <input type="checkbox"/> Yes <input type="checkbox"/> No							
List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.							
Name the drug		Strength and frequency taken:			Purpose of medication		
Allergies to: Eggs <input type="checkbox"/> Yes <input type="checkbox"/> No Soybean Oil <input type="checkbox"/> Yes <input type="checkbox"/> No Sulfites <input type="checkbox"/> Yes <input type="checkbox"/> No							
Allergies to medications:							
Name the drug		Reaction you had					