



CONFIDENTIAL HEALTH HISTORY

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Patient Name: _____

Date of Birth: _____

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes No Is your general health good?
If NO, explain _____
2. Yes No Has there been a change in your health within the last year?
If YES, explain _____
3. Yes No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
If YES, explain _____
4. Yes No Are you being treated by a physician now? If YES, explain _____
Date of last medical exam? Reason for exam _____
5. Yes No Have you had problems with prior dental treatment?
If YES, explain _____
Date of last dental exam Name of last treating dentist _____
6. Yes No Are you in pain now?
If YES, explain _____

II. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (Please Circle)

- | | | |
|--------------------------------|--------------------------|-------------------------|
| Chest pain (angina) | Blood in stools | Frequent vomiting |
| Fainting spells | Diarrhea or constipation | Jaundice |
| Recent significant weight loss | Frequent urination | Dry mouth |
| Fever | Difficulty urinating | Excessive thirst |
| Night sweats | Ringling in ears | Difficulty swallowing |
| Persistent cough | Headaches | Swollen ankles |
| Coughing up blood | Dizziness | Joint pain or stiffness |
| Bleeding problems | Blurred vision | Shortness of breath |
| Blood in urine | Bruise easily | Sinus problems |

III. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING/ (Please Circle)

- | | | |
|---------------------------------|---------------------------------|----------------------------|
| Heart disease | AIDS/HIV | Psychiatric care |
| Family history of heart disease | Surgeries | Osteoporosis |
| Heart attack | Hospitalization | Thyroid disease |
| Artificial joint | Diabetes | Asthma |
| Stomach problems or ulcers | Family history of diabetes | Hepatitis |
| Heart defects | Tumors or cancer | Sexual transmitted disease |
| Heart murmurs | Chemotherapy | Herpes |
| Rheumatic fever | Radiation | Canker or cold sores |
| Skin disease | Arthritis, rheumatism | Anemia |
| Hardening of arteries | Emphysema or other lung disease | Liver disease |
| High blood pressure | Kidney or bladder disease | Eye disease |
| Seizures | Stroke | Transplants |
| Cosmetic surgery | Eating disorders | Tuberculosis |

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? NO YES (Please Circle)

- | | | |
|---|--------------|--------------|
| Aspirin | Valium | Tetracycline |
| Darvon | Demerol | Vicodin |
| Codeine | Penicillin | Percodan |
| Local anesthetic (Novacaine or Xylocaine) | Latex | Food |
| Nitrous oxide | Erythromycin | Metal |
| Others: _____ | | |

PLEASE INITIAL _____

V. MEDICATIONS: LIST ANY MEICATIONS YOU ARE CURRENTLY TAKING:

_____	_____
_____	_____
_____	_____

VI. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS? (Please Circle)

- | | | |
|-----------------------------|--------------------------|-------------|
| Recreational drugs | Tobacco in any form | Antibiotics |
| Over-the -counter medicines | Alcohol | Supplements |
| Weight loss medications | Bisphosphonate (Fosamax) | Aspirin |

VII. WOMEN ONLY:

- Yes No Are you or could you be pregnant?
If YES, what month? _____
- Yes No Are you nursing?
- Yes No Are you taking birth control pills?

VIII. ALL PATIENTS

- Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?
- Yes No Have you ever been premedicated for dental treatment? If YES, why _____
- Yes No Have you ever taken Fen-phen? If YES, when, _____
- Yes NO Is there any issue or condition that you would like to discuss with the dentist in private? _____

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

Patient's Signature, _____ Date: _____

Physician's Name, _____ Phone Number _____

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 or Guardian) Date Signature of Dentist Date

Health Classification: _____