G. Mitchell Turk DDS
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CONFIDENTIAL HEALTH HISTORY

Patient name: _____ Date of birth: _____

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

DO YOU HAVE ANY CONCERNS WITH YOUR ORAL HEALTH? _____

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING?	YES	NO	NOTES		YES	NO	NOTES
Chest pain (angina)				Ringing in ears			
Fainting spells				Headaches/dizziness/ blurred vision			
Recent significant weight loss				Frequent vomiting			
Night sweats				Jaundice			
Persistent cough/coughing up blood				Dry mouth/excessive thirst			
Bleeding problems/bruise easily				Difficulty swallowing			
Blood in urine/stool				Shortness of breath			
Diarrhea/constipation				Joint pain/stiffness			
Frequent/difficulty urinating				Sinus problems			
Swollen ankles				Other:			
HAVE YOU HAD OR HAVE ANY OF THE FOLLOWING...	**YES**	**NO**	**NOTES**		**YES**	**NO**	**NOTES**
Heart disease/heart attack				Heart defects/murmurs			
Stomach problems/ulcers				Rheumatoid fever			
High cholesterol				Seizures			
High blood pressure				AIDS/HIV			
Surgeries/hospitalization				Tumors/cancer			
Diabetes				Chemotherapy/radiation			
Arthritis/rheumatism				Eating disorders			
Psychiatric care				Asthma			
Hepatitis				Anemia			
Sexually transmitted disease				Herpes/canker or cold sores			
Osteoporosis				Thyroid disease			
Emphysema/lung disease				Kidney/bladder disease			
Liver disease				Tuberculosis			
Eye disease				Transplants/artificial joints			
Human papillomavirus (HPV)				Other:			

ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING?

☐ Aspirin	☐ Local anesthetic	☐ Latex	☐ Ethryomycin	☐ Percodan	☐ Other:_____
☐ Darvon	☐ Nitrous oxide	☐Penicillin	☐ Tetracycline	☐ Food	☐ Other: _____
☐Codeine	☐ Valium	☐ Demerol	☐ Vicodin	☐ Metal	☐ Other: _____

PLEASE INITIAL: _____ DATE: _____

Patient name: _____ Date: _____

LIST ANY MEDICATIONS YOU ARE NOW TAKING...	DOSE/FREQUENCY	PURPOSE

ARE YOU TAKING OR HAVING YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS?

☐ Recreational drugs ☐ Tobacco ☐ Antibiotics

☐ Over-the-counter medicines ☐ Alcohol ☐ Supplements

☐ Weight loss medications ☐ Bisphosphonate (Fosamax) ☐ Aspirin

WOMEN ONLY:

1. Are you or could you be pregnant? ☐ Yes ☐ No
   If YES, what month? _____
2. Are you nursing? ☐ Yes ☐ No
3. Are you taking birth control pills? ☐ Yes ☐ No

ALL PATIENTS:

1. Have you ever been pre-medicated for dental treatment? ☐ Yes ☐ No
   If YES, why? _____
2. Have you ever taken Fen-phen? ☐ Yes ☐ No
   If YES, when? _____
3. Is there any issue or condition that you would like to discuss with the dentist in private? ☐ Yes ☐ No
4. Are you happy with the appearance of your smile? ☐ Yes ☐ No
5. Would you like whiter teeth? ☐ Yes ☐ No

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: _____