CONFIDENTIAL HEALTH HISTORY

G. Mitchell Turk DDS
714-921-2110
gmturk@mouthdoc.com

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 _____
6. Yes No Date of last dental exam Name of last treating dentist _____
   Are you in pain now?
7. Yes No If YES, explain _____
   Do you have any concerns regarding your oral health?_____

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	Ringing 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 Hepatitis
Stomach problems or ulcers	Family history of diabetes	Sexual transmitted disease
Heart defects	Tumors or cancer	Herpes
Heart murmurs	Chemotherapy	Canker or cold sores
Rheumatic fever	Radiation	Anemia
Skin disease	Arthritis, rheumatism	Liver disease
Hardening of arteries	Emphysema or other lung disease	Eye disease
High blood pressure	Kidney or bladder disease	Transplants
Seizures	Stroke	Tuberculosis
Cosmetic surgery	Eating disorders	High Cholesterol

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TOANY 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 _____ DATE _____

[redacted]

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If YES. explain _____
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4. Yes No Date of last medical exam? Reason for exam _____
Have you had problems with prior dental treatment?
If YES. explain _____
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6. Yes No If YES, explain _____

7. **DO YOU HAVE ANY CONCERNS REGARDING YOUR ORAL HEALTH?**_____

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

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Fainting spells
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Fever
Night sweats
Persistent cough
Coughing up blood
Bleeding problems
Blood in urine
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Ringing in ears
Headaches
Dizziness
Blurred vision
Bruise easily
Frequent vomiting
Jaundice
Dry mouth
Excessive thirst
Difficulty swallowing
Swollen ankles
Jaw Joint pain or stiffness
Shortness of breath
Sinus problems
Sensitive Teeth
Snoring
Sucking on lemons
Oral tobacco
Sleep Apnea/daytime fatigue

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

Heart disease
Family history of heart disease
Heart attack
Artificial joint
Stomach problems or ulcers
Heart defects
Heart murmurs
Rheumatic fever
Skin disease
Hardening of arteries
High blood pressure
Seizures
Cosmetic surgery
AIDS/HIV
Surgeries
Hospitalization
Diabetes
Family history of diabetes
Tumors or cancer
Chemotherapy
Radiation
Arthritis, rheumatism
Emphysema or other lung disease
Kidney or bladder disease
Stroke
Eating disorders
Psychiatric care
Osteoporosis Thyroid
disease Asthma
Hepatitis
Sexual transmitted disease Herpes
Canker or cold sores
Anemia
Liver disease
Eye disease
Transplants
Tuberculosis
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Nitrous oxide
Valium
Demerol
Penicillin
Latex
Erythromycin
Tetracycline
Vicodin
Percodan
Food
Metal
Others: _____ _____ _____

PLEASE INITIAL _____ DATE: _____

V. MEDICATIONS: LIST ANY MEDICATIONS 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:_____

Patient Name_____

V. MEDICATIONS: LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING: ***LIST ADDITIONAL MEDICATIONS ON TH BACK OF THIS PAGE.***

Drug Name:_____ PURPOSE: _____

Drug Name:_____ PURPOSE: _____

Drug Name: _____ PURPOSE: _____

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

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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? _____

Yes No Are you happy with the appearance of your smile?_____

Yes No Would you like whiter teeth?_____

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

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