HEALTH HISTORY
PERSONAL/MEDICAL INFORMATION

NAME: _____ PHONE (RES) _____ (BUS) _____
ADDRESS: _____ POSTAL CODE:_____
DATE OF BIRTH: _____ AGE: ____ SEX: _____GENDER: _____ PRONOUN PREFERENCE: _____
OCCUPATION/STUDENT STATUS _____ PHYSICIAN: _____ ADDRESS: _____
PHONE: _____Date of last medical examination: _____ Reason: _____
Have you ever been hospitalized? _____ If yes, state why and date of each: _____
Any related complications? _____
In case of emergency notify: _____
Relation to client: _____ PHONE: (Residence) _____(Cell) _____

DO YOU OR HAVE YOU EVER HAD: (Please circle No or Yes)

1. Heart valve replacement	No	Yes
2. Heart attack	No	Yes
3. Previous Endocarditis	No	Yes
4. Treatment for heart disease/heart attack	No	Yes
5. Pain in chest following physical activity	No	Yes
6. High blood pressure/Low blood pressure	No	Yes
7. Congenital heart disease	No	Yes
8. Stroke/ TIA	No	Yes
9. Hepatitis, liver trouble, jaundice	No	Yes
10. A test for AIDS +results - results	No	Yes
11. Tuberculosis	No	Yes
12. A pacemaker	No	Yes
13. Lung or chest problems	No	Yes
14. Asthma	No	Yes
15. Sinus trouble	No	Yes
16. Shortness of breath	No	Yes
17. Immune disorders	No	Yes
18. Placement of prosthetic device	No	Yes
19. Medical/Dental Xrays	No	Yes
20. Cancer	No	Yes
21. Allergies/Sensitivities	No	Yes
22. Seizure or convulsions	No	Yes
23. Diabetes/Excessive urination	No	Yes
24. Kidney trouble	No	Yes
25. Radiotherapy/Chemotherapy	No	Yes
26. Sexually transmitted disease	No	Yes
27. An adverse reaction to local anesthetic	No	Yes
28. Hives or skin rash	No	Yes
29. Osteoporosis	No	Yes
30. Arthritis or rheumatism	No	Yes
31. Herpes or cold sores	No	Yes
32. Difficulty controlling bleeding:	No	Yes
a) when injured	No	Yes
b) following a dental extraction	No	Yes
33. Thyroid problems	No	Yes
34. Stomach problems	No	Yes
35. Migraine headaches	No	Yes
36. Hearing loss	No	Yes
37. A tendency to faint	No	Yes
38. Are you pregnant? Due date _____	No	Yes
39. Do you smoke/vape or chew tobacco?	No	Yes
40. Do you consume alcohol?	No	Yes
41. Do you use marijuana for	No	Yes
recreational/medical purposes?	No	Yes
42. Other significant health problem	No	Yes
43. Conditions or disease not listed	No	Yes

ARE YOU TAKING:

43. Antibiotics	No	Yes
44. Advil or Aspirin	No	Yes
45. Barbiturates (e.g., sleeping pills)	No	Yes
46. Narcotics (e.g., codeine)	No	Yes
47. Vitamins/herbal remedies	No	Yes
48. Blood thinners INR rate_____	No	Yes
49. Steroids	No	Yes
50. Bisphosphanates (Fosamax, Didrocal)	No	Yes
51. Birth Control	No	Yes
52. Hormone replacement	No	Yes
53. Required pre-medication prior to dental	No	Yes
treatment	No	Yes
54. Other prescriptions or recreational drugs	No	Yes

COMMENTS: (Elaboration on YES responses)

Date: _____
Student:_____
Dentist/Faculty: _____

The above health history is correct as I understand at this time.

_____
X Client, Parent/Guardian Signature