

# Dental Concepts

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## HEALTH HISTORY

### HEALTH INFORMATION

PLEASE PRINT

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

If completing this form for another person, what is your name and relationship to that person?  
\_\_\_\_\_

Is there anything you wish to discuss in private with the doctor? Yes \_\_\_\_\_ No \_\_\_\_\_

For the following questions, **circle Yes or No**. Your answers are for our records only and will be kept confidential.

- |   |     |    |   |     |    |
|---|-----|----|---|-----|----|
| 1. Are you in good health? .....  | Yes | No | 29. TB, Tuberculosis (Self, Family, Household) .....                      | Yes | No |
| 2. Has there been any change in your general health within the past year? ..... | Yes | No | 30. Persistent cough/ cough that produces blood .....                     | Yes | No |
| <b>Have you ever had or do you now have?</b>                                    |     |    |   |     |    |
| 3. Pacemaker .....  | Yes | No | 31. Arthritis or painful/swollen joints .....                             | Yes | No |
| 4. Heart Murmur .....   | Yes | No | 32. Artificial joint replacement .....                                    | Yes | No |
| 5. Mitral valve prolapse .....  | Yes | No | 33. Stomach ulcer or hyperacidity .....                                   | Yes | No |
| 6. Rheumatic heart disease .....  | Yes | No | 34. Kidney trouble or dialysis .....                                      | Yes | No |
| 7. Damaged heart valve .....  | Yes | No | 35. Persistent swollen glands in neck .....                               | Yes | No |
| 8. Heart trouble .....  | Yes | No | 36. Sexually transmitted disease .....                                    | Yes | No |
| 9. Heart attack .....   | Yes | No | 37. Epilepsy or other neurological disease .....                          | Yes | No |
| 10. Angina .....  | Yes | No | 38. Psychotherapy .....   | Yes | No |
| 11. High Blood Pressure .....   | Yes | No | 39. Problems with mental health .....                                     | Yes | No |
| 12. Arteriosclerosis (hardening of the arteries) .....                          | Yes | No | 40. Cancer .....  | Yes | No |
| 13. Stroke .....  | Yes | No | 41. Problems of the immune system .....                                   | Yes | No |
| 14. Chest pain upon exertion .....  | Yes | No | 42. Rheumatic fever or scarlet fever .....                                | Yes | No |
| 15. Shortness of breath after mild exercise or when lying down? .....           | Yes | No | 43. Abnormal bleeding .....   | Yes | No |
| 16. Swollen ankles .....  | Yes | No | 44. Blood transfusion .....   | Yes | No |
| 17. Congenital heart defect .....   | Yes | No | 45. Blood disorders such as anemia .....                                  | Yes | No |
| 18. Prosthetic (artificial) heart valve .....                                   | Yes | No | 46. Tumor or growth .....   | Yes | No |
| 19. Allergy .....   | Yes | No | 47. Allergic or other reaction to   |     |    |
| 20. Sinus trouble .....   | Yes | No | a. local anesthetics or dental anesthetics ....                           |     |    |
| 21. Asthma or hay fever .....   | Yes | No | b. Penicillin or other antibiotics .....                                  |     |    |
| 22. Fainting spells or seizures .....   | Yes | No | c. Sulfa drugs .....  |     |    |
| 23. Persistent diarrhea or recent weight loss .....                             | Yes | No | d. Barbiturates, sedatives, or sleeping pills ...                         |     |    |
| 24. Diabetes .....  | Yes | No | e. Aspirin .....  |     |    |
| 25. Hepatitis, jaundice or liver disease .....                                  | Yes | No | f. Codeine .....  |     |    |
| 26. AIDS or HIV infection .....   | Yes | No | g. Other .....  |     |    |
| 27. Thyroid problems .....  | Yes | No | <b>Women</b>  |     |    |
| 28. Respiratory problems, emphysema, bronchitis, etc. ....                      | Yes | No | 48. Are you pregnant? .....   |     |    |
|   |     |    | 49. Do you have any problems associated with your menstrual period? ..... |     |    |
|   |     |    | 50. Are you nursing? .....  |     |    |

Please explain YES answers above and list serious illnesses, operations and hospitalizations within past five years:  
\_\_\_\_\_

Are you taking any medications (including non prescription)? \_\_\_\_\_

Tobacco use: Current Past Never used Type \_\_\_\_\_ Amount per day \_\_\_\_\_ Date tobacco use stopped \_\_\_\_\_

Alcohol use: Current Past Never used Describe usage:  
\_\_\_\_\_

Names of your primary health care practitioners (MD, DC, DO, etc.):

Name \_\_\_\_\_ Specialty \_\_\_\_\_ City \_\_\_\_\_

Name \_\_\_\_\_ Specialty \_\_\_\_\_ City \_\_\_\_\_

Are you now under the care of a doctor? Yes No If Yes, what is the condition being treated?

\_\_\_\_\_

I certify that I have read and understood the above. I acknowledge that any questions I had about the inquiries above have been answered to my satisfaction. I will not hold my dentist, or any member of his staff, responsible for any errors that I may have made in the completion of this form.

\_\_\_\_\_  
SIGNATURE OF PATIENT, PARENT OR GUARDIAN

\_\_\_\_\_  
Date