

EMERYVILLE DENTAL CARE
PATIENT HEALTH HISTORY Confidential Information

6001 Shellmound St., Ste 125, Emeryville, CA 94608 (510) 595-1900 www.EmeryvilleDental.com ©

Patient Name: _____ Social Security Number: _____ - _____ - _____
Patient Address: _____ City _____ State _____ Zip _____
Birth Date: ____/____/____ Pulse: _____ Regular/Irregular Blood Press: ____/____(L) ____/____(R) Height ____' ____' Weight: _____ lbs

I. CIRCLE APPROPRIATE ANSWER (Please answer all & leave Blank if you do not understand question):

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
If YES, why? _____
4. Yes No Are you being treated by a physician now? For what condition? _____
Name, Address & Phone No. of your Physician: _____
Date of last medical exam? _____ Last Blood Test? _____ Date of last Dental Appointment: _____
5. Yes No Have you had problems with prior dental treatment? Why? _____
6. Yes No Are you in pain now? Where? _____ Describe? _____

II. HAVE YOU EXPERIENCED:

- | | |
|--|--|
| 7. Yes No Chest pain (angina)? How often? _____ | 21. Yes No Ringing in ears? |
| 8. Yes No Swollen ankles? | 22. Yes No Headaches? Severe/Frequent |
| 9. Yes No Shortness of breath? | 23. Yes No Fainting spells? |
| 10. Yes No Recent weight loss, fever, night sweats? | 24. Yes No Blurred vision? |
| 11. Yes No Persistent cough, coughing up blood? | 25. Yes No Seizures? Epilepsy? Grand Mal or Petite. How often? _____ |
| 12. Yes No Bleeding problems, bruising easily? | 26. Yes No Excessive thirst? |
| 13. Yes No Sinus problems? Medications: _____ | 27. Yes No Frequent urination? |
| 14. Yes No Difficulty swallowing? | 28. Yes No Dry mouth? |
| 15. Yes No Persistent Diarrhea, Constipation? Blood in stools? | 29. Yes No Jaundice? |
| 16. Yes No Frequent vomiting, nausea? | 30. Yes No Joint pain, stiffness? |
| 17. Yes No Difficulty urinating, blood in urine? | 31. Yes No Shingles? |
| 18. Yes No Jaw problems TMJ/TMD? | 32. Yes No Nervousness? |
| 19. Yes No Back Problems? Medications: _____ | 33. Yes No Insomnia? |
| 20. Yes No Dizziness? | 34. Yes No Sleep Apnea? |

III. DO YOU HAVE OR HAVE YOU HAD:

- | | |
|--|--|
| 35. Yes No Heart disease? | 48. Yes No AIDS or ARC? or HIV+?,
When will you take your HIV blood test? _____ |
| 36. Yes No Heart attack? Heart defects? Congenital Heart Defect? | 49. Yes No Tumors, cancer? |
| 37. Yes No Heart murmurs? | 50. Yes No Arthritis, rheumatism? |
| 38. Yes No Rheumatic fever? | 51. Yes No Eye diseases? Glaucoma? Medications _____ |
| 39. Yes No Stroke, hardening of arteries? | 52. Yes No Skin diseases? |
| 40. Yes No Mitral Valve Prolapse? Damage Heart Valve? | 53. Yes No Anemia? Bruise easily? |
| 41. Yes No High/Low Blood pressure? Medications: _____ | 54. Yes No Hemophiliac? Sickle Cell Disease? |
| 42. Yes No Scarlet Fever? | 55. Yes No VD (syphilis or gonorrhea)? |
| 43. Yes No Family history of diabetes, heart problems, tumors? | 56. Yes No Herpes? |
| 44. Yes No Hepatitis, other liver disease? Medications: _____ | 57. Yes No Kidney, bladder disease? |
| 45. Yes No Stomach problems, ulcers? Medications: _____ | 58. Yes No Thyroid, adrenal disease? |
| 46. Yes No Allergies to: drugs, foods, medications, latex? | 59. Yes No Diabetes? Type I or Type II Medications: _____ |
| 47. Yes No Asthma, TB, emphysema, other lung diseases?
What triggers your asthma? _____
Medications? _____ | 60. Yes No Liver Problems? |
| | 61. Yes No the drug Phen-fen &/or Redux? When? _____ |

IV. DO YOU HAVE OR HAVE YOU HAD:

- | | |
|---|---|
| 62. Yes No Pacemaker? | 67. Yes No Hospitalization? Year(s) _____ For _____ |
| 63. Yes No Radiation treatments? Chemotherapy? | 68. Yes No Blood transfusions? Year(s) _____ |
| 64. Yes No Neurological Disorders? | 69. Yes No Surgeries? Year(s) _____ For _____ |
| 65. Yes No Prosthetic (Artificial) heart valve? | 70. Yes No Psychiatric care, Psychiatric Problems? |
| 66. Yes No Artificial joint? (hip, knee, or other joints) | 71. Yes No Contact lenses? |

V. ARE YOU TAKING:

- | | |
|--|--|
| 72. Yes No Recreational drugs? | 76. Yes No Antacids? How often? _____ |
| 73. Yes No Tobacco in any form? How many per day? _____ | 77. Yes No St. John's Wort Antifungal |
| 74. Yes No Alcoholic Beverages? How Often? _____ | 78. Yes No Herbal Supplements?; Herbal Drinks? |
| 75. Yes No Drugs, medications, OTC medicines (including Aspirin), natural remedies? Please list medications (and reason for taking): _____ | |

VI. WOMEN ONLY:

- | | |
|---|---|
| 79. Yes No Are you or could you be pregnant or nursing? | 81. Yes No Are you planning a pregnancy in the next 6 mos/12 mos? |
| 80. Yes No Taking birth control pills (BCP?) (use another form of BCP while taking antibiotics such as but not limited to, Penicillin, Amoxicillin, &/or Clindamycin) | |

VII. ALL PATIENTS: (Grapefruit in the last 48 hours?)

82. How often do you eat? _____ 83. How often do you drink cranberry juice? _____ grapefruit juice? _____
84. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If so, please explain: _____

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.
"Your Smile Starts Here..." Get the Healthy Smile You Deserve.

Patient's signature: _____ Date: _____

RECALL REVIEW:

- | | |
|------------------------------|-------------|
| 1. Patient's signature _____ | Date: _____ |
| 2. Patient's signature _____ | Date: _____ |
| 3. Patient's signature _____ | Date: _____ |