

# LASER & COSMETIC DENTISTRY

## Confidential Health History

Patient Name: \_\_\_\_\_ Soc. Sec. No.: \_\_\_\_\_ Birth Date: \_\_\_\_\_

**I. CIRCLE APPROPRIATE ANSWER** (leave Blank if you do not understand question):

- |           |  |                           |       |
|-----------|--|---------------------------|-------|
| 1. Yes No | Is your health good?   | Name of M.D.:             | _____ |
| 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?                          |                           | _____ |
|           | Date of last medical exam:   | Date of last dental exam: | _____ |
| 5. Yes No | Have you had problems with prior dental treatment? Please explain:           |                           | _____ |
| 6. Yes No | Are you in pain now?   |                           | _____ |

**II. HAVE YOU EXPERIENCED:**

- |            |  |            |                        |
|------------|--|------------|------------------------|
| 7. Yes No  | Chest Pain (angina)?                     | 18. Yes No | Dizziness?             |
| 8. Yes No  | Swollen ankles?                          | 19. Yes No | ringing in ears?       |
| 9. Yes No  | Shortness of breath?                     | 20. Yes No | Headaches?             |
| 10. Yes No | Recent weight loss, fever, night sweats? | 21. Yes No | Fainting spells?       |
| 11. Yes No | Persistent cough, coughing up blood?     | 22. Yes No | Blurred vision?        |
| 12. Yes No | Bleeding problems, bruising easily?      | 23. Yes No | Seizures?              |
| 13. Yes No | Sinus problems?                          | 24. Yes No | Excessive thirst?      |
| 14. Yes No | Difficulty swallowing?                   | 25. Yes No | Frequent urination?    |
| 15. Yes No | Diarrhea, constipation, blood in stools? | 26. Yes No | Dry mouth?             |
| 16. Yes No | Frequent vomiting, nausea?               | 27. Yes No | Jaundice?              |
| 17. Yes No | Difficulty urinating, blood in urine?    | 28. Yes No | Joint pain, stiffness? |

**III. DO YOU HAVE OR HAVE YOU HAD:**

- |            |   |            |                             |
|------------|---|------------|-----------------------------|
| 29. Yes No | Heart disease?                                      | 40. Yes No | AIDS?                       |
| 30. Yes No | Heart attack, heart defects?                        | 41. Yes No | Tumors, cancer?             |
| 31. Yes No | Heart murmurs or Rheumatic Fever?                   | 42. Yes No | Arthritis, rheumatism?      |
| 32. Yes No | Osteonecrosis?                                      | 43. Yes No | Eye disease?                |
| 33. Yes No | Stroke, hardening of arteries?                      | 44. Yes No | Skin diseases?              |
| 34. Yes No | High blood pressure?                                | 45. Yes No | Anemia?                     |
| 35. Yes No | Asthma, TB, emphysema, other lung diseases?         | 46. Yes No | VD (syphilis or gonorrhea)? |
| 36. Yes No | Hepatitis, other liver disease?                     | 47. Yes No | Herpes?                     |
| 37. Yes No | Stomach problems, ulcers?                           | 48. Yes No | Kidney, bladder disease?    |
| 38. Yes No | Allergies to: drugs, foods, medications, latex?     | 49. Yes No | Thyroid, adrenal disease?   |
| 39. Yes No | Family history of diabetes, heart problems, tumors? | 50. Yes No | Diabetes?                   |

**IV. DO YOU HAVE OR HAVE YOU HAD:**

- |            |                         |            |                     |
|------------|-------------------------|------------|---------------------|
| 51. Yes No | Psychiatric care?       | 56. Yes No | Hospitalization?    |
| 52. Yes No | Radiation treatments?   | 57. Yes No | Blood transfusions? |
| 53. Yes No | Chemotherapy?           | 58. Yes No | Surgeries?          |
| 54. Yes No | Prosthetic heart valve? | 59. Yes No | Pacemaker?          |
| 55. Yes No | Artificial joint?       | 60. Yes No | Contact lenses?     |

**V. ARE YOU TAKING:**

- |            |  |            |                      |
|------------|--|------------|----------------------|
| 61. Yes No | Recreational drugs?  | 63. Yes No | Tobacco in any form? |
| 62. Yes No | Drugs, medications, over-the-counter medicines<br>(including Aspirin), natural/homeopathic remedies? | 64. Yes No | Alcohol?             |
|            |  | 65. Yes No | Herbals?             |

Please list: \_\_\_\_\_  
\_\_\_\_\_

**VI. WOMEN ONLY:**

- |            |  |            |                             |
|------------|--|------------|-----------------------------|
| 66. Yes No | Are you or could you be pregnant or nursing? | 67. Yes No | Taking birth control pills? |
|------------|--|------------|-----------------------------|

**VII. ALL PATIENTS:**

- |            |  |            |                                   |
|------------|--|------------|-----------------------------------|
| 68. Yes No | Have you ever taken fen-phen?  | 70. Yes No | Fosamax or other bisphosphonates? |
| 69. Yes No | Do you have or have you had any other disease 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. I have received and understand the "Notice of Privacy Practices" which became effective February 17, 2010. I have received a copy of the "Dental Material Fact Sheet" published May 2004 as required by law.*

Patient's signature: _____	Date: _____
Doctor's signature: _____	Date: _____
Hygienist's signature: _____	Date: _____

