

HEALTH HISTORY

At the Log Cabin Dental Office we wish to provide you with optimum care. Correct answers to the following questions will allow Dr. Lee and his staff to treat you more individually and provide the care appropriate to your individual needs.

Name _____ Date of Birth _____ Age _____

Physicians Name _____ Phone _____

Please answer each question. Check yes or no. If in doubt, Please leave blank.

	YES	NO
Are you in good health now?	<input type="checkbox"/>	<input type="checkbox"/>
Are you now under the care of a physician?	<input type="checkbox"/>	<input type="checkbox"/>
If so, what is the condition being treated?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been hospitalized or had a serious illness?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, explain _____		
Have you ever had excessive bleeding after an extraction, or do cuts take longer to heal now than previously?	<input type="checkbox"/>	<input type="checkbox"/>
(Women) Are you pregnant? If yes, give due date. _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you use tobacco in any form? if yes, how much?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use alcoholic beverages? (more than 2 drinks per day).	<input type="checkbox"/>	<input type="checkbox"/>

Do you have or have you ever had any of the following?

	YES	NO		YES	NO
EYES			EARS		
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Loss of hearing.	<input type="checkbox"/>	<input type="checkbox"/>
EARS			Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>
Loss of hearing.	<input type="checkbox"/>	<input type="checkbox"/>	RESPIRATORY		
Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis.	<input type="checkbox"/>	<input type="checkbox"/>
NERVOUS SYSTEM			Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Stroke.	<input type="checkbox"/>	<input type="checkbox"/>	Asthma/hay fever.	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Persistent cough	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	HEART/BLOOD VESSELS		
Numbness/tingling	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever.	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness/fainting	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric treatment	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain/discomfort	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINE			Heart attack/trouble	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes.	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath.	<input type="checkbox"/>	<input type="checkbox"/>
BONES/MUSCLES			Swelling of ankles	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis/rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure.	<input type="checkbox"/>	<input type="checkbox"/>
Artificial joints.	<input type="checkbox"/>	<input type="checkbox"/>	Congenital heart disease	<input type="checkbox"/>	<input type="checkbox"/>
DIGESTIVE SYSTEM			Artificial heart valve.	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice.	<input type="checkbox"/>	<input type="checkbox"/>	Heart surgery.	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers.	<input type="checkbox"/>	<input type="checkbox"/>	BLOOD		
URINARY			Bruise easily.	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion.	<input type="checkbox"/>	<input type="checkbox"/>
OTHER					
Radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>			
Tumors or growths.	<input type="checkbox"/>	<input type="checkbox"/>			
Cancer	<input type="checkbox"/>	<input type="checkbox"/>			
Aids	<input type="checkbox"/>	<input type="checkbox"/>			

Are you ALLERGIC to or have you ever experienced any reactions to the following?

	YES	NO
Local anesthetics	<input type="checkbox"/>	<input type="checkbox"/>
(eg. Novocain)		
Barbiturates, Sedatives,		
Sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin/other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Codeine	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs.	<input type="checkbox"/>	<input type="checkbox"/>
Other allergies _____		

Are you taking any of the following?

	YES	NO
Antibiotics/sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>
Blood thinners	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure medication	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid medicine.	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone/steroids	<input type="checkbox"/>	<input type="checkbox"/>
Antihistamines/allergy		
drugs/cold remedies	<input type="checkbox"/>	<input type="checkbox"/>
Tranquilizers	<input type="checkbox"/>	<input type="checkbox"/>
Insulin/other diabetes drug	<input type="checkbox"/>	<input type="checkbox"/>
Recreational drugs.	<input type="checkbox"/>	<input type="checkbox"/>
Digitalis/heart medicines.	<input type="checkbox"/>	<input type="checkbox"/>
Nitroglycerine	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin.	<input type="checkbox"/>	<input type="checkbox"/>
Birth control pills.	<input type="checkbox"/>	<input type="checkbox"/>
Fosamax	<input type="checkbox"/>	<input type="checkbox"/>
Actonel	<input type="checkbox"/>	<input type="checkbox"/>
Aredia	<input type="checkbox"/>	<input type="checkbox"/>
Zometa	<input type="checkbox"/>	<input type="checkbox"/>
Other medication _____		

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or my medication, I will inform the dentist or hygienist at any next appointment.

Signature of Patient, Parent or Guardian _____

Date _____