JOSLYN SMILE CENTER
816 Joslyn Avenue
Pontiac, MI 48340
www.oihn.org

HEALTH HISTORY

Patient Name: _____ Birth date: _____

I. CIRCLE THE APPROPRIATE ANSWER (leave blank if you do not understand):

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? _____
			Date of last medical exam_____ Date of last dental exam_____
5.	Yes	No	Have you had problems with prior dental treatment?
6.	Yes	No	Are you in pain now?

II. HAVE YOU EXPERINENCED:

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

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?	42.	Yes	No	Arthritis, rheumatism?
32.	Yes	No	Rheumatic fever?	43.	Yes	No	Eye disease?
33.	Yes	No	Stroke, hardening of arteries?	44.	Yes	No	Skin disease?
34.	Yes	No	High blood pressure?	45.	Yes	No	Anemia?
35.	Yes	No	Asthma, TB, emphysema, lung disease?	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 food, drugs, 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?				
62.	Yes	No	Drugs, medications, over-the-counter medicines (including aspirin), natural remedies?	63.	Yes	No	Tobacco in any form?
				64.	Yes	No	Alcohol?

Please list: _____

_____

PLEASE TURN PAGE OVER

VI. WOMEN ONLY:

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

VII. ALL PATIENTS:

67. Yes No Do you have 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 changes in my health and/or medication.

Patient's signature: _____ Date: _____

RECALL REVIEW:

1. Patient's signature: _____ Date: _____

2. Patient's signature: _____ Date: _____

3. Patient's signature: _____ Date: _____