JOSLYN SMILE CENTER
816 Joslyn Avenue
Pontiac, MI 48340
www.honorcommunityhealth.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)?
8. Yes No Swollen ankles
9. Yes No Shortness of breath?
10. Yes No Recent weight loss, fever, night sweats?
11. Yes No Persistent cough, coughing up blood?
12. Yes No Bleeding problems, bruising easily?
13. Yes No Sinus problems?
14. Yes No Difficulty swallowing?
15. Yes No Diarrhea, constipation, blood in stools?
16. Yes No Frequent vomiting, nausea?
17. Yes No Difficulty urinating, blood in urine?
18. Yes No Dizziness?
19. Yes No Ringing in ears?
20. Yes No Headaches?
21. Yes No Fainting spells?
22. Yes No Blurred vision?
23. Yes No Seizures?
24. Yes No Excessive thirst?
25. Yes No Frequent urination?
26. Yes No Dry mouth?
27. Yes No Jaundice?
28. Yes No Joint pain, stiffness?

III. DO YOU HAVE OR HAVE YOU HAD:

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

IV. DO YOU HAVE OR HAVE YOU HAD:

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