

VISTA PACIFIC DENTAL CARE

CONFIDENTIAL HEALTH HISTORY

Please complete both sides of this form.

Patient Name: _____ Date of Birth: _____

I. CHECK APPROPRIATE ANSWER

- | | Yes | No | |
|----|--------------------------|--------------------------|--|
| 1. | <input type="checkbox"/> | <input type="checkbox"/> | Is your general health good? If NO, explain _____ |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | Has there been a change in your health within the last year? If YES, explain _____ |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | Have you gone to the hospital or emergency room or had a serious illness in the last three years? If YES, explain _____ |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> | Are you being treated by a physician now? If YES, explain _____ Date of last medical exam _____ Reason for exam _____ |

II. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING?

- | | | |
|---|---|--|
| <input type="checkbox"/> Chest pain (angina) | <input type="checkbox"/> Blood in urine or stools | <input type="checkbox"/> Frequent vomiting |
| <input type="checkbox"/> Endocarditis | <input type="checkbox"/> Diarrhea or constipation | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Dry mouth |
| <input type="checkbox"/> Recent significant weight loss | <input type="checkbox"/> Difficulty urinating | <input type="checkbox"/> Excessive thirst |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Headaches | <input type="checkbox"/> Swollen ankles |
| <input type="checkbox"/> Persistent cough | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Joint pain or stiffness |
| <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Sinus problems |

III. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING?

- | | | |
|--|--|---|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Psychiatric care |
| <input type="checkbox"/> Family history of heart disease | <input type="checkbox"/> Surgeries | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Hospitalization | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Artificial joint | <input type="checkbox"/> Family history of diabetes | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Stomach problems or ulcers | <input type="checkbox"/> Tumors or cancer | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Heart defects | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Heart murmurs | <input type="checkbox"/> Radiation | <input type="checkbox"/> Canker or cold sores |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Arthritis, rheumatism | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Skin disease | <input type="checkbox"/> Emphysema or other lung disease | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Kidney or bladder disease | <input type="checkbox"/> Eye disease |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Stroke | <input type="checkbox"/> Transplants |
| <input type="checkbox"/> Cosmetic surgery | <input type="checkbox"/> Eating disorders | <input type="checkbox"/> Tuberculosis |

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO ANY OF THE FOLLOWING?

- | | | |
|--|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Valium | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Darvon | <input type="checkbox"/> Demerol | <input type="checkbox"/> Vicodin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Percodan |
| <input type="checkbox"/> Local anesthetic (Novacaine or Xylocaine) | <input type="checkbox"/> Latex | <input type="checkbox"/> Food |
| <input type="checkbox"/> Nitrous oxide | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Metal |

Others: _____

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS?

- | | | |
|---|---|--|
| <input type="checkbox"/> Recreational drugs | <input type="checkbox"/> Tobacco in any form | <input type="checkbox"/> Antibiotics |
| <input type="checkbox"/> Over-the-counter medications | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Supplements (Vitamins, Herbs) |
| <input type="checkbox"/> Weight loss medications | <input type="checkbox"/> Bisphosphonate (Fosamax) | <input type="checkbox"/> Aspirin |

Please list all medications: _____

VI. WOMEN ONLY

Yes No

- Are you or could you be pregnant?
If YES, how far along? _____
- Are you nursing?
- Are you taking birth control?

VII. ALL PATIENTS

Yes No

- Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, please explain: _____
- Have you ever been pre-medicated for dental treatment? If YES, why? _____
- Have you ever taken Fen-phen? If YES, when? _____
- Is there any issue or condition that you would like to discuss with the dentist in private?

VII. DENTAL HISTORY

Yes No

1. Are you experiencing any dental problems now?
If YES, explain _____
2. Have you had any problems with prior dental treatment?
If YES, explain _____
Date of last dental exam _____ Name of last treating dentist _____
3. Are you nervous about having dental treatment?
4. Do your gums bleed when you are brushing or flossing?
5. Do you clench or grind your teeth?
6. Do you have pain, clicking or popping in your jaw joint (TMJ)?
7. Do you have any sensitive teeth?
If YES, where _____
What is the sensitivity to? (hot/cold, sweets, biting, etc...) _____
8. Have you had any of the following:
 - Orthodontic Treatment
 - Periodontal Treatment
 - Oral Surgery
9. Are you happy with the appearance of your smile?
10. Would you like to change the appearance of your smile?
If YES, what changes would you like to make?
 - Whiter teeth
 - Close spaces
 - Straighter teeth
 - Repair chips
 - Change shape of teeth
 - Other _____

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature: _____ Date: _____

Physician's Name: _____ Phone number: _____

I certify that I have read and understand this form. 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. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient (Parent or Guardian) Date

Signature of Dentist Date