HEALTH HISTORY

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Patient's Name________________________ Soc. Sec. No.___________
Birth Date_________________

Welcome to our office. Will you please fill out this short Health History form so we may be aware of any problems you may have or have had. We will see you in just a few minutes. Thank you again for coming in for your appointment.

Sincerely, David G. Ticzon, DDS and Annie K. Krystal, DDS

Primary reason for this appointment: Exam Emergency Consultation

1) Y / N Is your general health good?
2) Y / N Has there been a change in your health within the last year?
3) Y / N Have you been hospitalized or had a serious illness in the last 3 years? Why?_______
4) Y / N Are you being treated by a physician now? What?______________________________
5) Y/ N Have you had problems with prior dental treatment? What?_____________________
6) Y/ N Are you in pain now? Where?____
7) Is there something you do not like about your smile?
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Please **CIRCLE** YES or No for each of the following:

HAVE YOU EXPERIENCED?

Y	N	Chest pains (angina)?	Y	N	Dizziness?
Y	N	Swollen ankles?	Y	N	Ringing in ears?
Y	N	Shortness of breath	Y	N	Headaches
Y	N	Recent weight loss, fever, night sweats?	Y	N	Fainting spells?
Y	N	Persistent cough. Coughing up blood?	Y	N	Blurred vision?
Y	N	Bleeding problems, bruising easily?	Y	N	Seizures?
Y	N	Sinus problems?	Y	N	Excessive thirst?
Y	N	Difficulty swallowing?	Y	N	Frequent urination?
Y	N	Diarrhea, Constipation, Blood in Stools?	Y	N	Dry Mouth?
Y	N	Frequent vomiting, Nausea	Y	N	Jaundice?
Y	N	Difficulty urinating, blood in Urine?	Y	N	Joint pain, stiffness?

DO YOU HAVE OR HAVE YOU HAD?

Y	N	Heart disease?	Y	N	AIDS, ARC, HIV+
Y	N	Heart attack, heart defects?	Y	N	Tumors, Cancer?
Y	N	Heart murmurs?	Y	N	Arthritis, Rheumatism?
Y	N	Rheumatic fever?	Y	N	Eye Diseases?
Y	N	Stroke, hardening of arteries?	Y	N	Skin diseases?
Y	N	High blood pressure?	Y	N	Anemia?
Y	N	TB, Emphysema, other lung disease?	Y	N	VD (Syphilis or Gonorrhea)?
Y	N	Hepatitis, other liver disease?	Y	N	Herpes?
Y	N	Stomach problems, ulcers?	Y	N	Kidney, Bladder disease?
Y	N	ALLERGIES: to drugs, foods, medications?	Y	N	Thyroid disease?
Y	N	Psychiatric Care?	Y	N	Adrenal disease?
Y	N	Radiation Treatment?	Y	N	Recent hospitalization?
Y	N	Chemotherapy?	Y	N	Blood transfusion?
Y	N	Prosthetic heart valve?	Y	N	Surgeries?
Y	N	Artificial joint?	Y	N	Pacemaker?
Y	N	Contact lenses?	Y	N	Diabetes ?

ARE YOU TAKING?

Y	N	Recreational Drugs?	Y	N	Tobacco in any form?
Y	N	Drugs medicines, (including Aspirin)?	Y	N	Alcohol?

drugs:____.

WOMEN ONLY

Y	N	Are you or could you be pregnant or nursing?	Y	N	Are you on Birth Control Pills?

ALL PATIENTS

Y / N Are you taking or have you taken **Bisphosphonate** drug?

Y / N Do you have or have had any other diseases or medical problems **NOT** listed on this form?
What?____

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.

Patient's Signature________________________.
Date_________________. Blood Pressure______

Recall Review:
Patient's Signature/Date________________________/_________ Blood Pressure______
Patient's Signature/Date________________________/_________ Blood Pressure______
Patient's Signature/Date________________________/_________ Blood Pressure______

Drs. Ticzon's / Krystal's Interview Notes:
MEDICAL ALERTS: ____
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HEAD AND NECK PHYSICAL EXAM

WNL Scalp	WNL Lips	WNL Lateral Tongue
WNL Facial Skin	WNL Buccal Mucosa	WNL Ventral Tongure
WNL Facial Symmetry	WNL Parotid Flow	WNL Dorsal Tongue
WNL Eyes	WNL Gingiva	WNL Hard Palate
WNL Salivary Glands	WNL Oral Floor	WNL Soft Palate
WNL Neck	WNL SMG Flow	WNL Hands
WNL Oropharynx		