Siskiyou Community Health Center

HEALTH HISTORY

Patient Name _____ Chart # _____

Date of Birth _____

I. Circle Appropriate Answer (Leave blank if you do not understand the question)

Yes **No** Is your general health good?

Yes **No** Has there been a change in your health in the last year?

Yes **No** Are you under the care of a physician? If Yes, Name & Phone _____

If Yes, what is the condition being treated _____

Date of last medical exam _____

Yes **No** Have you been hospitalized or had a serious illness in the last three years?

If Yes, Please explain: _____

Yes **No** Have you had problems with prior dental treatment? _____ Date of last Dental exam _____

Yes **No** Are you in pain now? Describe _____

II. Do You Have or Have You Had:

Yes	**No**	Bleeding Problems, Bruising Easily	**Yes**	**No**	Thyroid, Adrenal Disease
Yes	**No**	Sinus Problems	**Yes**	**No**	Diabetes
Yes	**No**	Stroke, Hardening of Arteries	**Yes**	**No**	Seizures
Yes	**No**	Heart Disease	**Yes**	**No**	Dry Mouth
Yes	**No**	Heart Attack, Heart Defects	**Yes**	**No**	HIV or AIDS
Yes	**No**	Blood Transfusions	**Yes**	**No**	Tumors or Cancer
Yes	**No**	Heart Murmur	**Yes**	**No**	Radiation Treatments
Yes	**No**	Prosthetic Heart Valve	**Yes**	**No**	Chemotherapy (Pills and/or Injections)
Yes	**No**	Pacemaker	**Yes**	**No**	STD (Syphilis, Herpes or Gonorrhea)
Yes	**No**	Rheumatic Fever	**Yes**	**No**	Arthritis, Rheumatism
Yes	**No**	High Blood Pressure	**Yes**	**No**	Asthma, TB, Emphysema, other lung disease
Yes	**No**	Artificial Joint	**Yes**	**No**	Hepatitis, other Liver Disease
Yes	**No**	Stomach Problems, Ulcers	**Yes**	**No**	Kidney or Bladder Disease
Yes	**No**	Psychiatric Care	**Yes**	**No**	Osteoporosis

III. Are You Taking:

Yes **No** Recreational Drugs

Yes **No** Alcohol, Beer, or Wine

Yes **No** Tobacco (Pipes, Cigars, Cigarettes, Chew)

Yes **No** Drugs, Medications or over-the-counter medications (including Aspirin), Natural Remedies:

Please list: _____

IV. Women Only:

Yes **No** Birth Control Method: _____

Yes **No** Are you or could you be Pregnant or Nursing?

V. 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: _____

_____

Yes **No** **Allergies to: Drugs, Foods, Latex:** _____

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 medications.

Signature of Patient/Guardian _____ ***Date*** _____ ***Updated*** _____

Signature of Dentist _____ ***Date*** _____ ***Updated*** _____

Hygienist Initials _____

HEALTH HISTORY

This Section for Providers only:

Assessment Notes:

Recall Review: (Every 6 to 12 Months)

Patient _____ Date _____ Provider _____ Date _____

Patient _____ Date _____ Provider _____ Date _____

Patient _____ Date _____ Provider _____ Date _____