LAJOLLA DENTAL IMAGE

CONFIDENTIAL HEALTH HISTORY

Patient Name _____ Date of Birth _____

I. CHECK APPROPRIATE ANSWER

	YES	NO	
1.	☐	☐	Is your general health good? If NO, explain: _____
2.	☐	☐	Has there been a change in your health within the last year? If YES, explain: _____
3.	☐	☐	Have you gone to the hospital or emergency room or had a serious illness in the last three years? If YES, explain: _____
4.	☐	☐	Are you being treated by a physician now? If YES, explain _____
			Date of last exam _____ Reason for exam _____
5.	☐	☐	Have you had problems with prior dental treatment? If YES, explain: _____
			Date of last dental exam _____ Name of last treating dentist _____
6.	☐	☐	Are you In pain now? If YES, explain: _____

II. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
☐	☐	Chest pain (angina)	☐	☐	Blood in stool	☐	☐	Frequent vomiting
☐	☐	Fainting spells	☐	☐	Diarrhea/constipation	☐	☐	Jaundice
☐	☐	Recent weight loss	☐	☐	Frequent urination	☐	☐	Dry mouth
☐	☐	Fever	☐	☐	Difficulty urinating	☐	☐	Excessive thirst
☐	☐	Night sweats	☐	☐	Ringing in ears	☐	☐	Difficulty swallowing
☐	☐	Persistent cough	☐	☐	Headaches	☐	☐	Swollen ankles
☐	☐	Coughing up blood	☐	☐	Dizziness	☐	☐	Joint pain or stiffness
☐	☐	Bleeding problems	☐	☐	Blurred vision	☐	☐	Shortness of breath
☐	☐	Blood in urine	☐	☐	Bruise easily	☐	☐	Sinus problems

Other _____

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

YES	NO		YES	NO		YES	NO	
☐	☐	Heart disease	☐	☐	AIDS/HIV	☐	☐	Psychiatric care
☐	☐	Family History of Heart Disease	☐	☐	Surgeries	☐	☐	Osteoporosis
☐	☐	Heart Attack	☐	☐	Hospitalization	☐	☐	Thyroid Disease
☐	☐	Artificial joint	☐	☐	Diabetes	☐	☐	Asthma
☐	☐	Stomach problems/ulcers	☐	☐	Family history of Diabetes	☐	☐	Hepatitis
☐	☐	Heart defects	☐	☐	Tumors/cancer	☐	☐	Sexually transmitted disease
☐	☐	Heart murmurs	☐	☐	Chemotherapy	☐	☐	Herpes
☐	☐	Rheumatic fever	☐	☐	Radiation	☐	☐	Canker/cold sores
☐	☐	Skin disease	☐	☐	Arthritis, rheumatism	☐	☐	Anemia
☐	☐	Hardening of arteries	☐	☐	Emphysema/lung disease	☐	☐	Liver disease
☐	☐	High blood pressure	☐	☐	Kidney/bladder disease	☐	☐	Eye disease
☐	☐	Seizures	☐	☐	Stroke	☐	☐	Transplants
☐	☐	Cosmetic surgery	☐	☐	Eating disorders	☐	☐	Tuberculosis

Other: _____

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

YES	NO		YES	NO		YES	NO	
☐	☐	Aspirin	☐	☐	Valium or sedatives	☐	☐	Codeine or other opioids
☐	☐	Penicillin/other antibiotics	☐	☐	Latex	☐	☐	Food
☐	☐	Nitrous oxide	☐	☐	Local anesthetic	☐	☐	Metal
☐	☐	Other:						

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

YES	NO		YES	NO		YES	NO	
☐	☐	Recreational drugs	☐	☐	Tobacco in any form	☐	☐	Antibiotics
☐	☐	Over-the-counter meds	☐	☐	Alcohol	☐	☐	Supplements
☐	☐	Weight loss medications	☐	☐	Bisphosphonate (Fosamax)	☐	☐	Aspirin
☐	☐	Anti-depressants	☐	☐	Herbal supplements	☐	☐	
☐	☐	Opioids (e.g. Norco, Vicodin, Percocet, Percodan) If YES, explain reason:						

Please list all prescription medications _____

VI. WOMEN ONLY

YES	NO		
☐	☐	Are you or could you be pregnant?	If YES, what month? _____
☐	☐	Are you nursing?	
☐	☐	Are you taking birth control pills?	

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?

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 Signature _____ Date _____

Physician's Name _____ Phone # _____

Whom would you like us to contact in case of an emergency?

Name _____ **Relationship?** _____ **Phone** _____

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