CONFIDENTIAL HEALTH HISTORY

Patient Name: _____ **Date of Birth:** _____

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

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

II. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes/No	Chest pain (angina)	Yes/No	Frequent vomiting	Yes/No	Jaundice
Yes/No	Fainting spells	Yes/No	Frequent urination	Yes/No	Dry mouth
Yes/No	Recent significant weight loss	Yes/No	Ringing in ears	Yes/No	Excessive thirst
Yes/No	Persistent cough	Yes/No	Headaches	Yes/No	Difficulty swallowing
Yes/No	Coughing up blood	Yes/No	Dizziness	Yes/No	Joint pain or stiffness
Yes/No	Bleeding problems	Yes/No	Blurred vision	Yes/No	Shortness of Breath
Yes/No	Bruise easily	Yes/No	Sinus problems	Yes/No	Problem with TMJ
Yes/No	Blood transfusion	Yes/No	Drug addiction	Yes/No	Allergies or hives

III. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes/No	Heart disease	Yes/No	AIDS/HIV	Yes/No	Psychiatric care
Yes/No	Artificial heart valve	Yes/No	Surgeries	Yes/No	Osteoporosis/Osteopenia
Yes/No	Heart Attack	Yes/No	Leukemia	Yes/No	Thyroid disease
Yes/No	Artificial joint	Yes/No	Diabetes	Yes/No	Asthma
Yes/No	Stomach problems or ulcers	Yes/No	Ulcers	Yes/No	Hepatitis A, B. C
Yes/No	Congenital heart defects	Yes/No	Tumors or cancer	Yes/No	Sexual transmitted disease
Yes/No	Heart murmurs	Yes/No	Chemotherapy/Radiation	Yes/No	Herpes
Yes/No	Rheumatic or Scarlet fever	Yes/No	Eating Disorders	Yes/No	Canker or cold sores
Yes/No	Heart pacemaker	Yes/No	Arthritis, rheumatism	Yes/No	Anemia
Yes/No	Hardening of arteries	Yes/No	Emphysema or other lung disease	Yes/No	Liver disease
Yes/No	High blood pressure	Yes/No	Kidney or bladder disease	Yes/No	Eye disease (Glaucoma)
Yes/No	Seizures/Epilepsy	Yes/No	Stroke	Yes/No	Transplants
Yes/No	Irregular heartbeat	Yes/No	Human papillomavirus/HPV	Yes/No	Tuberculosis
Yes/No	Mitral Valve prolapse	Yes/No	Skin disease	Yes/No	Hemophilia

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING?
(Please circle Yes or No for each)

Yes/No	Aspirin	Yes/No	Valium	Yes/No	Tetracycline
Yes/No	Darvon	Yes/No	Demerol	Yes/No	Vicodin
Yes/No	Codeine	Yes/No	Penicillin	Yes/No	Percodan
Yes/No	Latex	Yes/No	Nitrous oxide	Yes/No	Metal
Yes/No	Erythromycin	Yes/No	Local anesthetic (Novocaine or Xylocaine)		
Yes/No	Food				

Any Others not listed? Please list_____

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes/No	Recreational drugs	Yes/No	Tobacco in any form	Yes/No	Antibiotics
Yes/No	Over-the-counter medicines	Yes/No	Alcohol	Yes/No	Supplements
Yes/No	Weight loss medications	Yes/No	Aspirin		
Yes/No	Cortisone medicine	Yes/No	X-ray/Cobalt treatment	Yes/No	Other

Please list ALL Medications currently taking: _____
_____

VI. WOMEN ONLY (Please circle Yes or No for each)

Yes/No Are you or could you be pregnant? If YES, what month? _____
Yes/No Are you nursing?
Yes/No Are you taking birth control pills?

VII. ALL PATIENTS (Please circle Yes or No for each)

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 Have you ever been pre-medicated for dental treatment? If YES, why? _____
What kind of medication prescribed? _____
Who prescribed it for you? _____
Yes/No Have you ever taken Fen-Phen? If YES, when? _____
Yes/No Have you ever been prescribed any bone building drugs such as: Prolia, Didronel, Zometa, Reclast, Boniva, Actonel, Aclasta, Binosto or Fosamax. If Yes, when? _____
Yes/No 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 potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize Richard L. Daffurn DDS to request, receive and discuss dental records and x-rays, as well as medical information pertinent to my dental treatment plan from my physician. This information may be x-rays, written or verbal, but will be limited to the minimum necessary for safe and comprehensive dental treatment. Even though some information may be handled by office staff, it will be considered confidential and will be treated in compliance with HIPAA regulations.

Your Physician's Name:_____ Phone #:_____
(not Dr. Daffurn)

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 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**

MEDICAL UPDATES
I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	PATIENT SIGNATURE	CHANGES TO HEALTH HISTORY	DENTIST INITIALS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____