Health History Form

Patient Information:

Patient Name: _____ Date: _____
Last, **First** **M.I.**

Gender: _____ Birth Date: _____ Phone: _____

Address: _____
Street Apartment #

_____
City State Zip code

Health Information:

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- ❑ AIDS
- ❑ Allergies _____
- ❑ Anemia
- ❑ Arthritis
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Blood Disease
- ❑ Cancer
- ❑ Diabetes
- ❑ Dizziness
- ❑ Epilepsy
- ❑ Excessive Bleeding
- ❑ Fainting
- ❑ Glaucoma
- ❑ Growths
- ❑ Hay Fever
- ❑ Head Injuries
- ❑ Heart Disease
- ❑ Heart Murmur
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ Jaundice
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Mental Disorders
- ❑ Nervous Disorders
- ❑ Pacemaker
- ❑ Pregnancy Due Date: _____
- ❑ Radiation Treatment
- ❑ Respiratory Problems
- ❑ Rheumatic Fever
- ❑ Rheumatism
- ❑ Sinus Problems
- ❑ Stomach Problems
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Tumors
- ❑ Ulcers
- ❑ Venereal Disease
- ❑ Codeine Allergy
- ❑ Penicillin Allergy
- ❑ Metal Allergy
- ❑ OTHER:
- ❑ _____
- ❑ _____

Have you ever had any complications following dental treatment? ❑ YES ❑ NO
If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? ❑ YES ❑ NO
If yes, please explain: _____

Are you now under the care of a physician? ❑ YES ❑ NO
If yes, please explain: _____

Name of Physician: _____ Phone: _____

Do you have any health problems that need further clarification? ❑ YES ❑ NO
If yes, please explain: _____

Please list all medications you are currently taking: _____
_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. I give McDonough County Health Department consent to refer me to participating dental providers of the Community Dental Assistance Program and to release the information on this form to the specific providers I am referred.

_____ Date: _____
Signature of Patient