

PATIENT HEALTH INFORMATION

Name: _____

Date: _____

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

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> AIDS or HIV | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Latex Sensitivity | <input type="checkbox"/> Sleep Disorders |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Excessive Bleeding
or Bruising | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Special Diet |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fainting or Dizziness | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Artificial Joints or Hip | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Head Trauma | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Thyroid Condition |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Weight Loss/Gain of
10 pounds in past year |
| <input type="checkbox"/> Rheumatoid Arthritis | | | |

Are you currently: Pregnant: Yes No Nursing: Yes No Taking Oral Contraception: Yes No

Do you have any allergies or adverse reactions to medications? Yes No

If yes, please list: _____

• Do you have any other health problems? Yes No

If yes, please explain: _____

• Have you ever had any complications during or following dental treatment? Yes No

If yes, please explain: _____

• Have you been hospitalized or had any serious illness or operation? 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: _____

• Date of your last physical: _____

Are you currently taking any medications or dietary/herbal supplements? Yes No If yes, please list:

	<u>Medication</u>	<u>Dosage</u>	<u>Condition Being Treated</u>
a.	_____	_____	_____
b.	_____	_____	_____
c.	_____	_____	_____
d.	_____	_____	_____

Your answers are for our records only and will be considered confidential.

To the best of my knowledge, all of my answers and information provided are true and correct.
If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

X _____ Date: _____

Signature of patient, parent or guardian

PERSONAL OVERALL HEALTH ASSESSMENT

Please rate each of the following symptoms based on your typical health profile over the past year.

POINT SCALE	
0 =	Never have the symptom
1 =	Almost never have the symptom
2 =	Occasionally have it, effect is not severe
3 =	Occasionally have it, effect is severe
4 =	Frequently have it, effect is not severe
5 =	Frequently have it, effect is severe

ENERGY/ACTIVITY	
	Fatigue/Sluggishness
	Apathy, lethargy
	Hyperactivity
	Restlessness
	Easy Fatigability or Lack of Endurance
	Headaches
	Faintness
	Dizziness
	Insomnia

EMOTIONAL/MENTAL	
	Mood Swings
	Anxiety, Fear, or Nervousness
	Anger or Irritability
	Depression
	Poor Memory
	Confusion, Poor Comprehension
	Poor Concentration
	Difficulty in Making Decisions
	Stuttering or Stammering
	Slurred Speech
	Learning Disabilities

JOINTS/MUSCLES/SKIN	
	Pain or aches in joints
	Stiffness or limitation of movement
	Pain or aches in muscles
	Feeling of weakness or tiredness
	Cramps in legs
	Acne
	Hives, rashes, or dry skin
	Hair loss
	Flushing or hot flashes
	Fingernail abnormalities (spots, ridges)
	Decreased sweating
	Night sweats

EARS/MOUTH/THROAT/NOSE/EYES	
	Itchy Ears
	Earaches, Ear Infections
	ringing in Ears, Hearing Loss
	Drainage from Ears
	Stuffy Nose
	Sinus Problems
	Hay Fever
	Excessive Mucus Formation
	Sneezing Attacks
	Poor Night Vision
	Watery or Itchy Eyes
	Swollen, Tender, or Sticky Eyelids
	Bags or Dark Circles Under Eyes
	Blurred or Tunnel Vision
	Chronic Coughing
	Sore Throat, Hoarseness, Voice Loss
	Swollen/Discolored Tongue, Gums, Lips
	Canker Sores

DIGESTIVE TRACT	
	Nausea or vomiting
	Diarrhea
	Constipation
	Bloated Feeling
	Belching, or passing gas
	Heartburn

HEART/LUNGS	
	Irregular or skipped heartbeat
	Rapid or pounding heartbeat
	Chest pain
	Chest congestion
	Asthma, bronchitis
	Shortness of breath

WEIGHT/OTHER	
	Binge eating/ drinking
	Craving certain foods
	Excessive weight
	Water retention
	Underweight
	Frequent illness
	Frequent or urgent urination
	Injury