LAKEFRONT FAMILY DENTISTRY
Derek B. Hauser, D.D.S.

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 three 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 in pain now?

   If YES, explain: _____

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

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

Other: _____

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

Yes / No Heart disease	Yes / No Asthma	Yes / No Anemia
Yes / No Family history of heart disease	Yes / No Stomach problems or ulcers	Yes / No Tuberculosis
Yes / No Heart attack	Yes / No Hepatitis	Yes / No Hardening of arteries
Yes / No Psychiatric care	Yes / No Emphysema/other lung disease	Yes / No Heart defects
Yes / No Tumors or cancer	Yes / No Liver disease	Yes / No Chemotherapy
Yes / No Surgeries (please explain below)	Yes / No Sexual transmitted disease	Yes / No High blood pressure
Yes / No Osteoporosis	Yes / No Heart murmurs	Yes / No Kidney or bladder disease
Yes / No AIDS/HIV	Yes / No Herpes	Yes / No Eye disease
Yes / No Hospitalization	Yes / No Rheumatic fever	Yes / No Seizures
Yes / No Thyroid disease	Yes / No Radiation	Yes / No Stroke
Yes / No Artificial joint	Yes / No Canker or cold sores	Yes / No Transplants
Yes / No Diabetes	Yes / No Skin disease	Yes / No Cosmetic surgery
Yes / No Diabetes; Do you take insulin?	Yes / No Arthritis, rheumatism	Yes / No Eating disorders
Yes / No Family history of diabetes		

Other: _____

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 Codeine or other narcotics
Yes / No Penicillin or other antibiotics
Yes / No Valium or other sedatives
Yes / No Latex
Yes / No Metal
Yes / No Food
Yes / No Nitrous oxide
Yes / No Local anesthetic

Others: _____

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS?
(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 Weight loss medications
Yes / No Aspirin
Yes / No Herbal Supplements
Yes / No Supplements
Yes / No Bisphosphonate (Fosamax)
Yes / No Anti-Depressants

Please list all prescription medications:

_____
_____
_____

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:
_____

Yes / No Have you ever taken Fen-Phen?
If YES, when:
_____

Yes / No Do you snore or have you ever been told that you snore?

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 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's Signature:_____ Date: _____

Physician's Name: _____ Phone Number:_____

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

Name: _____ **Relationship**: _____ **Phone Number**:_____

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