Patient Name:

Confidential Health History

I. Circle Appropriate Answer (Leave Blank if you do not understand the questions)

Is your general health good? Yes \ No
If No, explain:
_____

Has there been a change in your health within the last year? Yes \ No
If yes, explain:
_____
Have you gone to the hospital or emergency room or had a serious illness in the last three years? Yes \ No
If yes, explain:
_____

Are you being treated by a physician now? Yes \ No If yes explain: _____

Date of last medical exam? _____ Reason for exam? _____

Have you had problems with prior dental treatment? Yes \ No

If yes, explain? _____

Date of last dental exam: _____ Name of last treating dentist: _____

Are you in pain now? Yes \ No
If yes, explain? _____

II. Have you ever experienced any of the following? (Please Circle Yes or No for each)

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

III. Have you ever experienced any of the following? (Please circle Yes or No for each)

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

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 Penicillin or other antibiotics
Yes/ No Nitrous oxide
Yes/ No Valium or sedatives
Yes/ No Metal
Yes/ No Latex
Yes/ No Local anesthetic
Yes/ No Codeine or other opioids
Yes/ No Food
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 Over-the-counter medicines
Yes / No Weight loss medications
Yes / No Anti-Depressants
Yes / No Tobacco in any form
Yes / No Alcohol
Yes / No Bisphosphate (Fosamax)
Yes / No Herbal Supplements
Yes / No Antibiotics
Yes / No Supplements
Yes / No Aspirin
Opioids (e.g., Norco/Vicodin, Percocet, Percodan) If Yes, please explain reason: _____

_____

Please list all prescription medications: _____

VI. Vaccination: COVID-19 (Please circle for each, and fill in dose dates)
Yes / No / Prefer not to answer > Moderna, Pfizer, Johnson & Johnson, Other: _____ 1. _____ 2. _____ 3. _____4. _____

VII. 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?

VIII. All Patients (Please circle Yes or No for each)
Yes / No Do you have or have you had any other disease 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 **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 Dr. Farahmand 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 chance in my healthy 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 DDS/RDH – License # Date