CONFIDENTIAL HEALTH HISTORY

Name: _____ Date of Birth: _____

Gender: ▢ Male ▢ Female ▢ Gender Fluid

Please answer the following questions:

Is your general health good?	▢ Yes	▢ No
Has there been a change in your health within the last year?	▢ Yes	▢ No
Have you gone to the hospital or emergency room or had a serious illness in the last three years?	▢ Yes	▢ No
Are you being treated by a physician now, including annual wellness checkups?	▢ Yes	▢ No

Have you experienced any of the following? (check all that apply)

▢ Chest Pain/Angina	▢ Fainting Spells	▢ Recent weight loss
▢ Night Sweats	▢ Persistent Cough	▢ Coughing up blood
▢ Bleeding Problems	▢ Blood in stool	▢ Diarrhea or constipation
▢ Frequent Urination	▢ Difficult Urinating	▢ Ringing in ears
▢ Headaches	▢ Dizziness	▢ Blurry Vision
▢ Frequent vomiting	▢ Jaundice	▢ Dry Mouth
▢ Excessive thirst	▢ Difficulty swallowing	▢ Swollen ankles
▢ Joint pain or stiffness	▢ Shortness of breath	
▢ Other _____		

Have you ever had or do you have any of the following? (check all that apply)

▢ Heart Disease	▢ Family history of heart disease	▢ Heart attack
▢ Artificial Joints	▢ Stomach problems or ulcers	▢ Heart Defects
▢ AIDS/HIV	▢ Surgeries	▢ Hospitalization
▢ Diabetes	▢ Family history of diabetes	▢ Tumors or cancer
▢ Hardening of arteries	▢ High blood pressure	▢ Seizures
▢ Cosmetic Sugery	▢ Chemotherapy	▢ Radiation
▢ Arthritis, rheumatism	▢ Liver Disease	▢ Eye Disease
▢ Stroke	▢ Transplants	▢ Eating Disorders
▢ Tuberculosis	▢ Psychiatric care	▢ Osteoporosis
▢ Thyroid Disease	▢ Asthma	▢ Hepatitis
▢ Sexually Transmitted Disease	▢ Herpes	▢ Canker or cold sores
▢ Anemia	▢ Other _____	

Are you allergic to any of the following? (check all that apply)

▢ Codeine
▢ Penicillin or other antibiotics
▢ Nitrous oxide
▢ Local anesthetic
▢ Latex
▢ Other _____

Are you taking or have you taken any of the following in the last three months? (check all that apply)

▢ Recreational drugs
▢ Over-the-counter medicine
▢ Weight loss medications
▢ Anti-depressants
▢ Opioids (e.g. Norco, Vicodin, Percocet, Percodan)
▢ Tobacco (including e-cigarettes/vape)
▢ Alcohol
▢ Biphosphonate (Fosamax)
▢ Herbal Supplements
▢ Antibiotics
▢ Supplements
▢ Aspirin
▢ Other _____

Are you currently taking any prescription medications? ▢ Yes ▢ No

Do you smoke cigarettes, vape, or use smokeless tobacco? ▢ Yes ▢ No

If yes, please describe (packs per day, amount of nicotine, etc.) _____

Are you or could you be pregnant? ▢ Yes ▢ No

If yes, what month?

Are you taking birth control pills or other medical birth control? ▢ Yes ▢ No

Do you have or have you had any other diseases or medical problems NOT listed on this form? ▢ Yes ▢ No

Have you ever been pre-medicated for dental treatment? ▢ Yes ▢ No

Have you ever taken Fen Phen for weight loss? ▢ Yes ▢ No

Is there any other issue or condition that you would like to discuss with the dentist in private? ▢ Yes ▢ No

Do you currently see a chiropractor or cranio-sacral therapist? ▢ Yes ▢ No

Pharmacy Name & Phone Number: _____

Emergency Contact:

Name: _____ Relationship: _____

Phone Number: _____

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.

If necessary, I authorize Dela Rama Dental to contact my physician.

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.