GENERAL HEALTH CHART

Name _____ Social Security # _____

Address _____ City _____ Zip _____ Phone _____

E-mail _____ Fax _____ Mobile Phone _____

I would prefer to be addressed as _____ Referred By _____ Marital Status _____

Age _____ Date of Birth _____ Sex _____ Height _____ Weight _____ Spouse's Name _____

Occupation _____ Employer _____

Address _____ City _____ Zip _____ Phone _____

Most convenient: Appointment time _____ Contact time _____ Contact mode _____

PRESENT HEALTH:

1. How would you describe your present health? _____
2. Are you now under the care of a physician? ..... Yes No
3. Names, addresses, phone numbers, and specialties of all of your physicians _____
   _____
   _____
   _____
4. What medications, prescription and non-prescription, are you presently taking? _____
   _____
5. Are you sensitive to aspirin ☐, penicillin ☐, novocaine ☐, codeine ☐, or any other drug? ..... Yes No
   If so, describe _____
6. Do you require antibiotic premedication prior to dental care? ..... Yes No
7. Are you, or do you have any reason to believe you may be, HIV positive? ..... Yes No

PAST MEDICAL HISTORY:

8. Have you had any serious illness or operation? ..... Yes No
   If so, what and when? _____
9. Have you ever had any allergies? ..... Yes No
   If so, what and when? _____
10. Are you now taking, or have you ever taken, medication to prevent osteoporosis? ..... Yes No
    If so, what and when? _____

CARDIOVASCULAR:

11. Have you ever had any heart conditions? ☐ murmurs? ☐ ..... Yes No
12. Has your blood pressure ever been too high? ☐ too low? ☐ ..... Yes No
13. Have you ever had rheumatic fever? ☐ rheumatic heart disease? ☐ ..... Yes No
14. Are you subject to fainting spells? ☐ dizziness? ☐ chest pains? ☐ ..... Yes No
15. Have you ever had a stroke? ..... Yes No

HEMATOLOGY:

16. Have you ever had abnormal bleeding problems after a cut? ☐ tooth extraction? ☐ ..... Yes No
17. Do you bruise easily? ☐ bleed easily? ☐ ..... Yes No

ENDOCRINE:

18. Do you have diabetes? ..... Yes No
19. Have you ever received treatment for any endocrine or glandular disease? ..... Yes No

NEUROLOGY:

20. Do you suffer from frequent or severe headaches? ..... Yes No
21. Have you ever had severe pains of the head or face? ..... Yes No
22. Do you consider yourself excessively nervous? ..... Yes No
23. Have you ever had epilepsy or seizures? ..... Yes No
24. Have you ever suffered from depression? ..... Yes No

RESPIRATORY:

25. Do you ever become short of breath? ..... Yes No
26. Do you have asthma? ☐ emphysema? ☐ ..... Yes No
27. Have you had tuberculosis or a persistent cough? ..... Yes No
28. Do you smoke? If so, what and how much? _____ Yes No
29. Do you have sinus problems? If so, what kind? _____ Yes No

(COMPLETE OTHER SIDE)