

PLANO DENTAL ASSOCIATES / HEALTH HISTORY

Dr. William K. Swedenburg

Date: _____

Patient Name: _____

Social Security #: _____ - _____ - _____

Date of Birth _____

Height _____ Weight _____

Home phone: _____

Cell phone: _____

Street Address: _____

E-mail address: _____

Do we have your permission to share your dental information with your spouse? Yes No NA

Do we have your permission to share your dental information with your parents? Yes No NA

I. Circle Appropriate Answer (leave blank if you do not understand the question)

- Yes No Is your general health good?
- Yes No Has there been a change in your health within the last year?
- Yes No Have you been hospitalized or had a serious illness in the last three years?
Why? _____
- Yes No Are you being treated by a physician now? For what? _____
- _____ Date of last medical exam? _____ Date of last dental appt? _____
- Yes No Have you had problems with your prior dental treatment? Explain _____
- Physician's name _____ Telephone # _____
- Yes No Are you in pain now? If yes, where and what kind? _____

II. Have you experienced?

- | | |
|---|-------------------------------|
| Yes No Chest Pain (angina)? | Yes No Dizziness? |
| Yes No Swollen ankles? | Yes No Ringing in ears? |
| Yes No Shortness of breath? | Yes No Headaches? |
| Yes No Recent weight loss, fever, night sweats? | Yes No Fainting spells? |
| Yes No Persistent cough, coughing up blood? | Yes No Blurred vision? |
| Yes No Bleeding problems, bruising easily? | Yes No Seizures, epilepsy? |
| Yes No Sinus problems? | Yes No Excessive thirst? |
| Yes No Difficulty swallowing? | Yes No Frequent urination? |
| Yes No Diarrhea, constipation, blood in stools? | Yes No Dry mouth? |
| Yes No Frequent vomiting, nausea? | Yes No Jaundice? |
| Yes No Difficulty urinating, blood in urine? | Yes No Joint pain, stiffness? |

III. Do you have or have you had?

- | | |
|--|--|
| Yes No Heart disease? | Yes No AIDS, ARC, HIV infection? |
| Yes No Heart attack, heart defects? | Yes No Tumors, cancer? |
| Yes No Heart murmurs, mitral valve prolapse? | Yes No Arthritis, rheumatism? |
| Yes No Rheumatic fever? | Yes No Eye Diseases? |
| Yes No Stroke, hardening of arteries? | Yes No Skin Diseases? |
| Yes No High blood pressure? | Yes No Anemia, blood disease? |
| Yes No TB emphysema, other lung diseases? | Yes No VD(syphillis, gonorrhea, chlamydia) |
| Yes No Hepatitis, other liver disease, jaundice? | Yes No Herpes? |
| Yes No Stomach problems, ulcers? | Yes No Kidney, bladder disease? |
| Yes No ALLERGIES: to drugs, foods, medications others? | Yes No Thyroid, adrenal disease? |
| _____ | Yes No Diabetes? |
| Yes No Family history of diabetes, heart problems, tumors? | |

IV. Do you have or have you had?

- | | |
|--------------------------------|----------------------------|
| Yes No Psychiatric care? | Yes No Hospitalization? |
| Yes No Radiation treatments? | Yes No Blood transfusions? |
| Yes No Chemotherapy? | Yes No Surgeries? |
| Yes No Prosthetic heart valve? | Yes No Pacemaker? |
| Yes No Artificial joint? | Yes No Contact lenses? |

V. Do you use?

- | | |
|---|-----------------------------|
| Yes No Recreational drugs? | Yes No Tobacco in any form? |
| Yes No Drugs, medicines, (incl. Aspirin)? | Yes No Alcohol? |

Please list _____

VI. Women only:

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

VII. All patients:

Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If so please explain: _____

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.

Patient and/or Parent and/or Guardian Signature_____