Redlands Dental Surgery Center
Patient Health History

Patient Name: _____ Date of Birth: _____ Height: _____ Weight: _____

CIRCLE APPROPRIATE ANSWER (leave blank if unknown)

1. Yes No Is your general health good?
2. Yes No Have you been hospitalized or had a serious illness in the last three years?
   If yes, please explain: _____
3. Yes No Are your being treated by a physician now?
   If yes, please explain: _____
4. Yes No Have you had any problems with prior dental treatment?
   If yes, please explain: _____
5. Yes No Are you in pain now?
   If yes, please explain: _____
6. Yes No Allergies to medications, food, latex?
   If yes, please list: _____

HAVE YOU EXPERIENCED:

7. Yes No Chest Pain (Angina)
8. Yes No Swollen Ankles
9. Yes No Shortness of breath
10. Yes No Recent weight loss, fever, night sweats
11. Yes No Persistent cough
12. Yes No Bleeding or bruising easily
13. Yes No Sinus problems
14. Yes No Difficulty swallowing
15. Yes No Frequent vomiting, nausea
16. Yes No Dizziness
17. Yes No Ringing in ears
18. Yes No Headaches
19. Yes No Fainting spells
20. Yes No Seizures
21. Yes No Jaundice
22. Yes No Joint pain/stiffness
23. Other _____

DO YOU OR HAVE YOU HAD:

24. Yes No Heart disease/defects
25. Yes No Heart attack
26. Yes No Heart murmur
27. Yes No Down Syndrome
28. Yes No Rheumatic Fever
29. Yes No Stroke
30. Yes No High blood pressure
31. Yes No Lung disease (COPD, emphysema, bronchitis)
32. Yes No Asthma
33. Yes No TB
34. Yes No Hepatitis, other liver disease
35. Yes No Stomach problems, ulcers
36. Yes No Diabetes
37. Yes No AIDS or HIV
38. Yes No Cancer, tumors
39. Yes No Arthritis / Osteoarthritis
40. Yes No Cerebral Palsy
41. Yes No Skin Disease
42. Yes No Eye Disease
43. Yes No Anemia
44. Yes No Herpes
45. Yes No Kidney Disease
46. Yes No Thyroid problem
47. Yes No Autism / ADHD
48. Yes No Intellectual Disability (mild / moderate / profound)

Medical conditions NOT listed on this form?
Please explain: _____

DO YOU OR HAVE YOU HAD:

49. Yes No Psychiatric care
50. Yes No Radiation treatment
51. Yes No Chemotherapy
52. Yes No Prosthetic heart valve
53. Yes No Artificial joints
54. Yes No Surgery _____
55. Yes No Hospitalization
56. Yes No Blood transfusion
57. Yes No Pacemaker
58. Yes No Contact lenses
59. Yes No Dialysis
60. Yes No VNS

ARE YOU TAKING:

61. Yes No Medications: List: _____
62. Yes No Biophosphate: Have you taken or are you taking?
63. Yes No Tobacco
64. Yes No Alcohol
65. Yes No Recreational Drugs: List: _____

WOMEN ONLY:

66. Yes No Are you/could you currently be pregnant
67. Yes No Are you taking birth control
71. Yes No Currently Breastfeeding

_____ _____ _____

Date Patient/Parent/Guardian Signature Doctor Signature

RECALL REVIEW:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Date Patient/Parent/Guardian Signature Doctor Signature