Ho'ola Lahui Hawai'i
Kaua'i Community Health Center
Dental Department

CONFIDENTIAL HEALTH HISTORY

Print Form

Patient Name: ____________________ **Date of Birth:** ____________

I. Check the Appropriate Answer (Leave blank if you do not understand the question)

1. Is your general health good? ☐ Yes ☐ No

If NO, explain:

2. Has there been a change in your health within the last year? ☐ Yes ☐ No

If YES, explain:

3. Have you gone to the hospital or emergency room or had a serious illness in the last three years? ☐ Yes ☐ No

If YES, explain:

4. Are you being treated by a physician now? If yes, explain:

Date of last medical exam? Reason for exam:

5. Have you had problems with prior dental treatment? ☐ Yes ☐ No

If YES, explain:

6. Are you in pain now? ☐ Yes ☐ No

If YES, explain:

II. Have you recently experienced any of the following? (Please **check all** that applies)

☐ Chest pain (angia)	☐ Blood in stools	☐ Frequent Vomitting	☐ Fainting Spells
☐ Diarrhea or Constipation	☐ Jaundice	☐ Recent significant weight loss	☐ Frequent urination
☐ Dry mouth	☐ Fever	☐ Difficulty urinating	☐ Excessive thirst
☐ Night sweats	☐ Ringing in ears	☐ Difficulty swallowing	☐ Persistent cough
☐ Headaches	☐ Swollen ankles	☐ Coughing up blood	☐ Dizziness
☐ Joint pain or stiffness	☐ Bleeding problems	☐ Blurred vision	☐ Shortness of breath
☐ Blood in urine	☐ Bruise easily	☐ Sinus problems	☐ Other:

If Other, explain:

III. Have you ever had or do you have any of the following? (Please **check all** that applies)

☐ Heart disease	☐ AIDS / HIV	☐ Psychiatric care	☐ Surgeries
☐ Family history of heart disease	☐ Osteoporosis	☐ Heart attack	☐ Hospitalization
☐ Thyroid disease	☐ Artificial joint	☐ Diabetes	☐ Asthma
☐ Stomach problems or ulcers	☐ Hepatitis	☐ Heart defects	☐ Tumors or cancer
☐ Family history of diabetes	☐ Heart murmurs	☐ Chemotherapy	☐ Herpes
☐ Sexual transmitted disease	☐ Rheumatic fever	☐ Radiation	☐ Canker or cold sores
☐ Skin disease	☐ Arthritis, rheumatism	☐ Anemia	☐ Hardening of arteries
☐ Emphysema or other lung disease	☐ Liver disease	☐ High blood pressure	☐ Kidney or bladder disease
☐ Eye disease	☐ Seizures	☐ Stroke	☐ Transplants
☐ Cosmetic surgery	☐ Eating disorders	☐ Tuberculosis	☐ Other

If other, explain:

IV. Are you allergic to or have you had a reaction to any of the following? (Please check Yes or No for each)

Aspirin	☐ Yes	☐ No	Valium or sedatives	☐ Yes	☐ No
Codeine or other opioids	☐ Yes	☐ No	Penicillin or other antibiotics	☐ Yes	☐ No
Latex	☐ Yes	☐ No	Food	☐ Yes	☐ No
Nitrous oxide	☐ Yes	☐ No	Local anesthetic	☐ Yes	☐ No
Metal	☐ Yes	☐ No	☐ Other (Please explain)		

Other(s): ______________________________

V. Are you taking or have you taken any of the following in the last three months? Please check Yes or No for each)

Recreational Drugs	☐ Yes	☐ No	Tobacco in any form	☐ Yes	☐ No
Antibiotics	☐ Yes	☐ No	Over the counter medications	☐ Yes	☐ No
Alcohol	☐ Yes	☐ No	Supplements	☐ Yes	☐ No
Weight loss medications	☐ Yes	☐ No	Bisphosphonate (Fosamax)	☐ Yes	☐ No
Aspirin	☐ Yes	☐ No	Anti-Depressants	☐ Yes	☐ No
Herbal Supplements	☐ Yes	☐ No			

Opioids (e.g., Norco, Vicodin, Percocet, Percodan) If yes, please expain reason for taking: ☐ Yes ☐ No

Reason for taking Opioids: ______________________________

Please list all prescription medications: ______________________________

VI. Please check all of the following:

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

If yes, explain: ______________________________

Have you ever been pre-medicated for dental treatment? If YES, why? ☐ Yes ☐ No

If yes, explain: ______________________________

Have you ever taken Fen-Phen? If YES, when? ☐ Yes ☐ No When? ______________

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

VII. WOMEN ONLY: (Please check each of the following):

Are you or could you be pregnant? If YES, what month? ______________________________

Are you nursing? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No

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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.

Physician's Name ______________________________ Phone Number: ______________

I authorize the dentist to contact my physician. In addition, 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.

Patient Signature ______________________________ Date ______________

Emergency Contact Name ______________ Relationship: ______________ Phone Number: ______________

Signture of Dentist ______________________________ Date ______________

MEDICAL UPDATES

I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	PATIENT SIGNATURE	CHANGES TO HEALTH HISTORY	DENTIST INITIALS