HO'OLA LAHUI HAWAI'I
PHARMACY
KAUA'I COMMUNITY HEALTH CENTER

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

CONFIDENTIAL HEALTH HISTORY

Patient Name: _____ **Date of Birth:** _____

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. **Yes / No** Is your general health good?
   If NO, explain:_____
2. **Yes / No** Has there been a change in your health within the last year?
   If YES, explain: _____
3. **Yes / No** Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain: _____
4. **Yes / No** Are you being treated by a physician now? If YES, explain: _____
   Date of last medical exam? _____ Reason for exam: _____
   Primary Care Physician Name: _____ Phone Number: _____
5. **Yes / No** Have you had problems with prior dental treatment?
   If YES, explain: _____
   Date of last dental exam: _____ Name of last treating dentist: _____
6. **Yes / No** Are you in pain now?
   If YES, where and explain: _____

II. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No Chest pain (angina)	**Yes / No** Blood in stools	**Yes / No** Frequent vomiting
Yes / No Fainting spells	**Yes / No** Diarrhea or constipation	**Yes / No** Jaundice
Yes / No Recent significant weight loss	**Yes / No** Frequent urination	**Yes / No** Dry mouth
Yes / No Fever	**Yes / No** Difficulty urinating	**Yes / No** Excessive thirst
Yes / No Night sweats	**Yes / No** Ringing in ears	**Yes / No** Difficulty swallowing
Yes / No Persistent cough	**Yes / No** Headaches	**Yes / No** Swollen ankles
Yes / No Coughing up blood	**Yes / No** Dizziness	**Yes / No** Joint pain or stiffness
Yes / No Bleeding problems	**Yes / No** Blurred vision	**Yes / No** Shortness of breath
Yes / No Blood in urine	**Yes / No** Bruise easily	**Yes / No** Sinus problems

Other: _____

III. HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No Heart disease	**Yes / No** AIDS/HIV	**Yes / No** Psychiatric care
Yes / No Family history of heart disease	**Yes / No** Surgeries	**Yes / No** Osteoporosis
Yes / No Heart attack	**Yes / No** Hospitalization	**Yes / No** Thyroid disease
Yes / No Artificial joint: Type/ Date of surgery: _____		**Yes / No** Hepatitis
Yes / No Loss of hearing; full or partial	**Yes / No** Family history of diabetes	**Yes / No** Asthma
Yes / No Stomach problems or ulcers	**Yes / No** Tumors or cancer	**Yes / No** Diabetes
Yes / No Heart defects	**Yes / No** Sexually transmitted diseases	**Yes / No** Herpes
Yes / No Pacemaker: Date implanted: _____		**Yes / No** Heart murmur
Yes / No Chemotherapy	**Yes / No** Rheumatic fever	**Yes / No** Radiation
Yes / No Canker or cold sores	**Yes / No** Skin disease	**Yes / No** Arthritis, rheumatism
Yes / No Anemia	**Yes / No** Hardening of arteries	**Yes / No** Liver disease
Yes / No Emphysema or other lung disease	**Yes / No** High blood pressure	**Yes / No** Eye disease
Yes / No Kidney or bladder disease	**Yes / No** Seizures	**Yes / No** Stroke
Yes / No Transplants	**Yes / No** Cosmetic surgery	**Yes / No** Eating disorders
Yes / No Tuberculosis	**Yes / No** General Anesthesia	**Yes / No** Conscious Sedation
Yes / No Deep Sedation	**Yes / No** Moderate Sedation	**Yes / No** Mild/Minimal Sedation

Other: _____

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IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No Aspirin
Yes / No Penicillin or other antibiotics
Yes / No Nitrous oxide
Yes / No General Anesthesia
Yes / No Valium or sedatives
Yes / No Latex
Yes / No Local anesthetic
Yes / No Sedation Anesthesia
Yes / No Codeine or other opioids
Yes / No Food
Yes / No Metal
Yes / No Conscious Sedation

Others: _____

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS? (Please circle Yes or No for each)

Yes / No Recreational drugs
Yes / No Over-the-counter medicines
Yes / No Weight loss medications
Yes / No Antidepressants
Yes / No Tobacco in any form
Yes / No Alcohol
Yes / No Bisphosphonate (Fosamax)
Yes / No Herbal supplements type: _____
Yes / No Antibiotics
Yes / No Supplements
Yes / No Aspirin

Yes / No Opioids (e.g., Norco, Vicodin, Percocet, Percodan, Tramadol) If YES, please explain reason:

_____

Please list all prescription medications taken within the last 14 days:

_____

VI. WOMEN ONLY (Please circle Yes or No for each)

Yes / No Are you or could you be pregnant? If YES, how many months? _____
Yes / No Are you nursing?
Yes / No Are you taking birth control pills?

VII. ALL PATIENTS (Please circle Yes or No for each)

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

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

_____

Yes / No Are you currently under the care of a physician or taking any medications for any of the conditions listed above? If YES, please list: _____

Yes / No Are there any issues or conditions that you would like to discuss with the dentist in private?

_____

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. I authorize the dentist to contact my physician.

Physician's Name: _____ **Phone Number:** _____

Whom would you like us to contact in case of an emergency?

Name: _____ **Relationship:** _____ **Phone Number:** _____

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.

_____ _____
Signature of Patient (Parent or Guardian if patient is a minor) **Date**

_____ _____
Signature of Dentist **Date**