

# HEALTH HISTORY

CIRCLE ONE

1. Do you have a personal physician? ..... YES NO  
Physician's Name \_\_\_\_\_ Date of last physical examination \_\_\_\_\_  
Address \_\_\_\_\_ Phone # \_\_\_\_\_
2. Your current physical health is  Good  Fair  Poor
3. Have you been under the care of a Physician in the last two years? ..... YES NO  
If yes, please explain \_\_\_\_\_
4. Have you taken any prescription / over-the-counter medications or drugs during the past two years? ..... YES NO  
If yes, please list \_\_\_\_\_
5. Are you currently taking any prescription / over-the-counter medications or drugs of any kind? ..... YES NO  
If yes, please list \_\_\_\_\_
6. Do you now have, or have you ever had a substance abuse problem? ..... YES NO
7. Are you aware of being allergic to, or have you ever reacted adversely to any medication or substance? ..... YES NO  
If yes, please list \_\_\_\_\_
8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? ..... YES NO
9. Do your ankles swell during the day? ..... YES NO
10. Do you use more than 2 pillows to sleep? ..... YES NO
11. Have you lost or gained more than 10 pounds in the past year? ..... YES NO
12. Do you ever wake up from sleep short of breath? ..... YES NO
13. Have you ever had, or do you currently have any of the following diseases or medical problems?
- |                              |     |    |                           |     |    |                                  |     |    |
|------------------------------|-----|----|---------------------------|-----|----|----------------------------------|-----|----|
| Heart Attack                 | YES | NO | Endocrine or              | YES | NO | Emphysema                        | YES | NO |
| Stroke                       | YES | NO | Thyroid Problems          | YES | NO | Allergies/Hay Fever              | YES | NO |
| Heart Surgery                | YES | NO | Kidney Problems           | YES | NO | Arthritis/Rheumatism             | YES | NO |
| Heart Pacemaker              | YES | NO | Shingles                  | YES | NO | Drug/Alcohol Addiction           | YES | NO |
| Heart Murmur                 | YES | NO | Cold Sores/Fever Blisters | YES | NO | Problems with the                |     |    |
| Rheumatic Fever              | YES | NO | Severe/Frequent           |     |    | Immune System                    | YES | NO |
| Congenital Heart Defect      | YES | NO | Headaches                 | YES | NO | HIV+/Aids                        | YES | NO |
| Mitral Valve Prolapse        | YES | NO | Epilepsy/Seizures         | YES | NO | Hepatitis A (Infectious)         | YES | NO |
| Artificial Heart Valves      | YES | NO | Fainting/Dizzy Spells     | YES | NO | Hepatitis B                      | YES | NO |
| Artificial Joints            | YES | NO | Nervousness               | YES | NO | Liver Disease                    | YES | NO |
| (Hip, Knee, Etc.)            |     |    | Psychiatric Treatment     | YES | NO | Yellow Jaundice                  | YES | NO |
| High/Low Blood Pressure      | YES | NO | Diabetes                  | YES | NO | Venereal Disease                 | YES | NO |
| Anemia                       | YES | NO | Polio, Mumps, Pneumonia   | YES | NO | (Syphilis, Gonorrhea, Condyloma) |     |    |
| Blood Transfusion            | YES | NO | Tuberculosis              | YES | NO | Ulcers/Colitis                   | YES | NO |
| Hemophilia/Abnormal Bleeding | YES | NO | Difficulty Breathing      | YES | NO | Glaucoma                         | YES | NO |
| Sickle Cell Disease          | YES | NO | Sinus Problems            | YES | NO | Birth Defects or                 |     |    |
| Bruise Easily                | YES | NO | Adenoids Removed          | YES | NO | Hereditary Problems              | YES | NO |
| Cancer/Chemotherapy or       |     |    | Tonsils Removed           | YES | NO | Hospitalized For Any             |     |    |
| X-Ray Treatment              | YES | NO | Asthma                    | YES | NO | Reason                           | YES | NO |
14. Do you have any disease, condition, or problem not listed? ..... YES NO  
If yes, please explain \_\_\_\_\_
15. Have there been any injuries to the face, mouth, teeth, or chin? ..... YES NO
16. Do you now have, or have you ever experienced any jaw joint pain or discomfort? ..... YES NO
17. Are you aware of having any missing or extra permanent teeth? ..... YES NO
18. Have you ever had or been evaluated for orthodontic treatment before? ..... YES NO
19. Do you feel nervous about having orthodontic treatment, should it be indicated? ..... YES NO
20. What is your primary concern? (Why are you here?) \_\_\_\_\_

I have read and understand the above questions. I will not hold Dr. Dula or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status I will so inform Dr. Dula's office.

The undersigned hereby authorizes Dr. Dula to take X-rays, study models, photographs or any other diagnostic aids deemed appropriate by Dr. Dula to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Dula to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with (Name of Patient) \_\_\_\_\_, and further authorize and consent that Dr. Dula choose and employ such assistance as deemed fit. I understand that this office reserves the right to verify the credit status of potential patients and/or parents prior to extending credit for treatment fees and may, at its discretion, use the services of one or more credit reporting agencies.

Patient \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_

Parent or Guardian \_\_\_\_\_ Relationship to Patient \_\_\_\_\_