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Family and Cosmetic Dentistry

HEALTH HISTORY

NAME \_\_\_\_\_

PERSONAL PHYSICIAN \_\_\_\_\_

PLEASE CIRCLE Y FOR YES OR N FOR NO IN THE FOLLOWING LIST OF CONDITIONS --

- |   |   |                               |
|---|---|-------------------------------|
| 1. Y N HIGH CHOLESTEROL                     | 16. Y N DIABETES                        | 31. Y N HIV / AIDS / ARC      |
| 2. Y N HEART SURGERY / PACE MAKER           | 17. Y N FAINTING / DIZZINESS / SEIZURES | 32. Y N CHANGE IN WEIGHT      |
| 3. Y N HEART MURMUR / MITRAL VALVE PROLAPSE | 18. Y N INSOMNIA                        | 33. Y N EASILY FATIGUED       |
| 4. Y N RHEUMATIC FEVER / SCARLET FEVER      | 19. Y N NERVOUS DISORDER                | 34. Y N ULCERS / COLITIS      |
| 5. Y N HIGH / LOW BLOOD PRESSURE            | 20. Y N ASTHMA / HAYFEVER               | 35. Y N COUGH                 |
| 6. Y N SHINGLES                             | 21. Y N TUBERCULOSIS                    | 36. Y N COMMUNICABLE DISEASE  |
| 7. Y N PAIN IN CHEST                        | 22. Y N HEPATITIS                       | 37. Y N LIVER PROBLEM         |
| 8. Y N SHORTNESS OF BREATH                  | 23. Y N ARTHRITIS                       | 38. Y N KIDNEY PROBLEM        |
| 9. Y N SWOLLEN ANKLES                       | 24. Y N TUMOR / CANCER                  | 39. Y N PSYCHIATRIC TREATMENT |
| 10. Y N ANEMIA                              | 25. Y N EXCESSIVE BLEEDING              | 40. Y N DRUG DEPENDENCY       |
| 11. Y N HEADACHES                           | 26. Y N ARTIFICIAL BONES / JOINTS       | 41. Y N ALLERGIES             |
| 12. Y N SUPERVISED DIET                     | 27. Y N TOBACCO DEPENDENCY              | 42. Y N FEVER BLISTERS        |
| 13. Y N DRUG / ALCOHOL ABUSE                | 28. Y N MAJOR OPERATION                 | 43. Y N SINUS PROBLEMS        |
| 14. Y N STROKE / HEART ATTACK               | 29. Y N SERIOUS ACCIDENT                | 44. Y N ARTIFICIAL VALVES     |
| 15. Y N VENEREAL DISEASE                    | 30. Y N BLOOD TRANSFUSION               | 45. Y N EMPHYSEMA / GLAUCOMA  |

IF YES TO ANY OF THE ABOVE, PLEASE EXPLAIN (BY NUMBER) \_\_\_\_\_

PLEASE LIST ANY OTHER SERIOUS MEDICAL CONDITION(S) THAT YOU HAVE EVER HAD:

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING DRUGS?  PENICILLIN  ASPIRIN  ERYTHROMYCIN  LATEX  TETRACYCLINE  CODEINE

DENTAL ANESTHETICS  OTHER \_\_\_\_\_

REASON FOR TODAY'S VISIT:  EXAM  EMERGENCY  CONSULTATION

ARE YOU IN PAIN?  NO  YES HOW LONG? \_\_\_\_\_

PLEASE INDICATE ANY OF THE FOLLOWING PROBLEMS:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> DISCOMFORT, CLICKING OR POPPING IN JAW | <input type="checkbox"/> LOST/BROKEN FILLING(S) | <input type="checkbox"/> STAINED TEETH |
| <input type="checkbox"/> RED, SWOLLEN OR BLEEDING GUMS          | <input type="checkbox"/> TEETH GRINDING         | <input type="checkbox"/> LOCKING JAW   |
| <input type="checkbox"/> SENSITIVE TOOTH, TEETH OR GUMS         | <input type="checkbox"/> RINGING IN EARS        | <input type="checkbox"/> BAD BREATH    |
| <input type="checkbox"/> BLISTERS/SORES IN OR AROUND THE MOUTH  | <input type="checkbox"/> BROKEN/CHIPPED TOOTH   |  |
| <input type="checkbox"/> OTHER: _____                           |   |  |

LIST ALL MEDICATIONS (INCLUDING ASPIRIN, SLEEPING MEDICATION, SEDATIVES, HERBAL SUPPLEMENTS)

TAKING _____	FOR _____
TAKING _____	FOR _____
TAKING _____	FOR _____
TAKING _____	FOR _____

DO YOU NEED TO TAKE ANY MEDICATION PRIOR TO YOUR DENTAL APPOINTMENT? Y N

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

WOMEN: Y N PREGNANT / MONTH \_\_\_\_\_ Y N MENOPAUSE / SUPPORTIVE MEDICATION \_\_\_\_\_

I UNDERSTAND THAT THE INFORMATION THAT I HAVE GIVEN TODAY IS CORRECT TO THE BEST OF MY KNOWLEDGE. I ALSO UNDERSTAND THAT THIS INFORMATION WILL BE HELD IN THE STRICTEST CONFIDENCE AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY MEDICAL STATUS. I AUTHORIZE THE DENTAL STAFF TO PERFORM WITH MY INFORMED CONSENT, ANY NECESSARY DENTAL SERVICES I MAY NEED DURING DIAGNOSIS AND TREATMENT.

DATE

PATIENT'S / AUTHORIZED PERSONS SIGNATURE