Dr. Steven T. Kobayashi, D.D.S.

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: _____
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, explain: _____

II. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? *Please check all that apply*

- ☐ Chest Pain (angina)
- ☐ Fainting Spells
- ☐ Recent significant weight loss
- ☐ Fever
- ☐ Night Sweats
- ☐ Persistent Cough
- ☐ Coughing Up Blood
- ☐ Bleeding Problems
- ☐ Blood in Urine
- ☐ Blood in Stools
- ☐ Diarrhea or Constipation
- ☐ Frequent Urination
- ☐ Difficulty Urinating
- ☐ Ringing in Ears
- ☐ Headaches
- ☐ Dizziness
- ☐ Blurred Vision
- ☐ Bruise Easily
- ☐ Frequent Vomiting
- ☐ Jaundice
- ☐ Dry Mouth
- ☐ Excessive Thirst
- ☐ Difficulty Swallowing
- ☐ Swollen Ankles
- ☐ Joint Pain or Stiffness
- ☐ Shortness of Breath
- ☐ Sinus problems

III. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? *Please check all that apply*

- ☐ Heart Disease
- ☐ Family History of Heart Disease
- ☐ Heart Attack
- ☐ Artificial Joint
- ☐ Stomach Problems or Ulcers
- ☐ Heart Defects
- ☐ Heart Murmurs
- ☐ Rheumatic Fever
- ☐ Skin Disease
- ☐ Hardening of Arteries
- ☐ High Blood Pressure
- ☐ Seizures
- ☐ Cosmetic Surgery
- ☐ AIDS/HIV
- ☐ Surgeries
- ☐ Hospitalization
- ☐ Diabetes
- ☐ Family History of Diabetes
- ☐ Tumors or Cancer
- ☐ Chemotherapy
- ☐ Radiation
- ☐ Arthritis, Rheumatism
- ☐ Emphysema or Other Lung Disease
- ☐ Kidney or Bladder Disease
- ☐ Stroke
- ☐ Eating Disorder
- ☐ Psychiatric Care
- ☐ Osteoporosis
- ☐ Thyroid Disease
- ☐ Asthma
- ☐ Hepatitis
- ☐ Sexual Transmitted Disease
- ☐ Herpes
- ☐ Canker or Cold Sores
- ☐ Anemia
- ☐ Liver Disease
- ☐ Eye Disease
- ☐ Transplants
- ☐ Tuberculosis

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? *Please check all that apply*

- ☐ Aspirin
- ☐ Demerol
- ☐ Percodan
- ☐ Food
- ☐ Valium
- ☐ Vicodin
- ☐ Latex
- ☐ Metal
- ☐ Tetracycline
- ☐ Codeine
- ☐ Nitrous Oxide
- ☐ Local Anesthetic (Novacaine or Xylocaine)
- ☐ Darvon
- ☐ Penicillin
- ☐ Erythromycin

Others: _____

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS? *Please check all that apply*

- ☐ Recreational Drugs
- ☐ Alcohol
- ☐ Aspirin
- ☐ Tobacco in any form
- ☐ Supplements
- ☐ Antibiotics
- ☐ Weight Loss Medications
- ☐ Over-the-Counter Medicines
- ☐ Bisphosphonate (Fosamax)
- ☐ Other *Please List ALL Prescription Medication:* _____

_____

_____

HEALTH HISTORY FORM CONTINUED ON OTHER SIDE >

VI. WOMEN ONLY

YES NO Are you or could you be pregnant?
If YES, what month? _____

YES NO Are you nursing?

YES NO Are you taking birth control pills?

VII. ALL PATIENTS

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 Have you ever taken Fen-phen? If YES, when? _____

YES NO Is there any issue or condition 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.

_____ _____
PATIENT'S SIGNATURE DATE

_____ _____
PHYSICIAN'S NAME 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 medications. 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) DATE SIGNATURE OF DENTIST DATE

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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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____