Sonoma County Indian Health Project, Inc.

HEALTH HISTORY

Patient Name:_____ Patient Identification Number:_____

Birthdate:_____

I. CHECK APPROPRIATE ANSWER (leave Blank if you do not understand the question):

Yes	No	Question
		Is your general health good?
		Has there been a change in your health within the last year?
		Have you been hospitalized or had a serious illness in the last three years? If YES, why?
		Are you being treated by a physician now? For what? Date of last medical exam: Date of last Dental exam:
		Have you had problems with prior dental treatment?
		Are you in pain now?

II. HAVE YOU EXPERIENCED:

Yes	No	Question	Yes	No	Question
		Chest pain (Angina)?			Dizziness?
		Swollen ankles?			Ringing in ears?
		Shortness of breath?			Headaches?
		Recent weight loss, fever, night sweats?			Fainting spells?
		Persistent cough, coughing up blood?			Blurred vision?
		Bleeding problems, bruising easily?			Seizures?
		Sinus problems?			Excessive thirst?
		Difficulty swallowing?			Frequent urination?
		Diarrhea, constipation, blood in stools?			Dry mouth?
		Frequent vomiting, nausea?			Jaundice?
		Difficulty urinating, blood in urine?			Joint pain, stiffness?

III. DO YOU HAVE OR HAVE HAD:

Yes	No	Question	Yes	No	Question
		Heart disease?			AIDS?
		Heart attack, heart defects?			Tumors, cancer?
		Heart murmurs?			Arthritis, rheumatism?
		Rheumatic fever?			Eye diseases?
		Stroke, hardening of arteries?			Skin disease?
		High blood pressure?			Anemia?
		Asthma, TB, emphysema, other drug diseases?			VD (syphilis or gonorrhea)?
		Hepatitis, other liver disease?			Herpes?
		Stomach problems, ulcers?			Kidney, bladder disease?
		Allergies to: drugs, foods, medications, latex?			Thyroid, adrenal disease?
		Family history of diabetes, heart problems, tumors?			Diabetes?

IV. DO YOU HAVE OR HAVE HAD:

Yes	No	Question	Yes	No	Question
		Psychiatric care?			Hospitalization?
		Radiation treatments?			Blood transfusions?
		Chemotherapy?			Surgeries?
		Prosthetic heart valve?			Pacemaker?
		Artificial joint?			Contact lenses?

V. ARE YOU TAKING:

Yes	No	Question	Yes	No	Question
		Recreational drugs?			Tobacco in any form?
		Drugs, medications, over-the-counter medicines?			Alcohol?

Please list:

VI. WOMEN ONLY:

Yes	No	Question	Yes	No	Question
		Are you or could you be pregnant or nursing?			Taking birth control pills?

VII. All PATIENTS:

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

If so, please explain:

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 medical.

Patient's Signature:_____ Date:_____

RECALL REVIEW:

Patient's Name:_____ Date:_____

Patient's Name:_____ Date:_____

Patient's Name:_____ Date:_____