SMITH DENTAL CENTER
HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	**Today's Date:**
Previous or referring doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

SYMPTOMS

Check (√) conditions you currently have or have had in the past year

GENERAL	GASTROINTESTINAL	EYE/EAR/NOSE/THROAT	BODY (Pain/weakness)	CARDIOVASCULAR	SKIN
□ Chills	□ Appetite poor	□ Bleeding gums	□ Arms	□ High Blood pressure	□ Bruises easily
□ Depression	□ Bloating	□ Blurred vision	□ Back	□ Blood Clots	□ Hives
□ Dizziness	□ Bowel Changes	□ Crossed eyes	□ Feet	□ Chest pain	□ Itching
□ Fainting	□ Constipation	□ Difficulty swallowing	□ Hands	□ Low Blood pressure	□ Change in moles
□ Forgetfulness	□ Diarrhea	□ Double vision	□ Hips	□ Irregular heart beat	□ Rash
□ Headache	□ Excessive hunger	□ Earache	□ Legs	□ Murmur	□ Scares
□ Loss of Sleep	□ Excessive thirst	□ Ear Discharge	□ Neck	□ Poor circulation	□ Sore that won't heal
□ Loss of Weight	□ Gas	□ Hay Fever	□ Shoulders	□ Rapid heart beat	
□ Nervousness	□ Hemorrhoids	□ Hoarseness	**GENITO-URINARY**	□ Swelling of ankles	
□ Numbness	□ Indigestion	□ Loss of hearing	□ Blood in urine	□ Varicose blood	
□ Sweats	□ Nausea	□ Nose bleeds	□ Frequent urination		
	□Rectal Bleeding	□ Persistent cough	□ Lack of bladder control		
	□ Stomach pain	□ Ringing ears	□ Painful urination		
	□Vomiting	□ Sinus problems			
	□Vomiting blood	□ Vision flashes			

CONDITIONS

Check (√) conditions you currently have or have had in the past year

□ Alcoholism	□ Multiple Sclerosis	□ Asthma	□ Heart Attack	□ Migraines
□ Chemical Dependency	□ Appendicitis	□ Bronchitis	□ Congestive Heart Failure	□ Strokes
□ Psychiatric care	□ Cohn's	□ Emphysema/COPD	□ High Blood Pressure	□ Kidney Failure
□ Anemia	□ Hepatitis	□ Pneumonia	□ Blood clots	□ Kidney Stones
□ Bleeding disorder	□ Irritable Bowel	□ Tuberculosis	□ Pulmonary Embolism	□ Liver Disease
□ Breast lump	□ Ulcerative Colitis	□ Diabetes	□ Rheumatic Fever	□ Prostate Problem
□ Cancer	□ Ulcers	□ Goiter	□ Pacemaker	□ Cataracts
□ Herpes	□ Arthritis	□ Thyroid problems	□ High Cholesterol	□ Glaucoma
□ HIV Positive	□ Gout	□ Heart disease	□ Epilepsy Seizure disorder	

Surgeries

Year	Reason	Hospital

Other hospitalizations		
Year	**Reason**	**Hospital**

Have you ever had a blood transfusion?	☐ Yes	☐ No

List your prescribed medications and over-the-counter medications, such as vitamins and inhalers		
Name the medications		
Allergies to medications		
	Reaction You Had	

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# Of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	How many drinks per week?					
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	**SIGNIFICANT HEALTH PROBLEMS**
Father		
Mother		
Sibling	☐ M ☐ F	
	☐ M ☐ F	
	☐ M ☐ F	

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No

I certify that the above information is true to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or commissions that I may have made in the completion of this form.

Patient/Guardian signature ***Date***