JOHN RAVERA, DDS
GENERAL & COSMETIC DENTISTRY

HEALTH HISTORY

PATIENT NAME_____

CIRCLE APPROPRIATE ANSWER (leave BLANK if you do not understand question):

Yes No Is your general health good?
Yes No Has there been a change in your health within the last year?
Yes No Have you been hospitalized or had a serious illness in the past three years?
Why?_____
Yes No Are you being treated by a physician now? For what?_____
Date of your last physical_____/_____/_____
Yes No Have you had problems with prior dental treatment?
Yes No Are you in pain now?
Yes No Physician's name_____City_____Phone_____

HAVE YOU EXPERIENCED?

Yes No Chest pain (angina)
Yes No Swollen ankles
Yes No Shortness of breath
Yes No Recent weight loss, fever or night sweats
Yes No Persistent cough, coughing up blood
Yes No Bleeding problems, bruising easily
Yes No Sinus problems
Yes No Difficulty swallowing
Yes No Diarrhea, constipation, blood in slots
Yes No Frequent vomiting, nausea
Yes No Difficulty urinating, blood in urine

Yes No Dizziness
Yes No Ringing in the ears
Yes No Headaches
Yes No Fainting spells
Yes No Blurred vision
Yes No Seizures
Yes No Excessive thirst
Yes No Frequent urination
Yes No Dry mouth
Yes No Jaundice
Yes No Joint pain, stiffness

DO YOU HAVE OR HAVE YOU HAD?

Yes No Heart Disease
Yes No Heart attack, heart defects
Yes No Heart murmurs
Yes No Mitral Valve Prolapse
Yes No Rheumatic fever
Yes No Stroke, hardening of arteries
Yes No High blood pressure
Yes No Tuberculosis, emphysema, other lung diseases
Yes No Hepatitis, other liver disease
Yes No Stomach problems, ulcers
Yes No ALLERGIES: to drugs, foods, medications
Yes No Family history of diabetes, heart problems, tumors
Yes No Psychiatric care
Yes No Radiation treatments
Yes No Chemotherapy
Yes No Prosthetic heart valve
Yes No Artificial joint

Yes No HIV, Aids
Yes No Tumors, cancer
Yes No Arthritis, rheumatism
Yes No Eye diseases
Yes No Skin diseases
Yes No Anemia
Yes No VD (syphilis or gonorrhea or other)
Yes No Herpes
Yes No Kidney, bladder disease
Yes No Thyroid, adrenal disease
Yes No Diabetes

Yes No Hospitalization
Yes No Blood transfusions
Yes No Surgeries
Yes No Pacemaker
Yes No Contact lenses

ARE YOU TAKING OR DO YOU USE?

Yes No Recreational drugs, (Marijuana, Cocaine, etc.)
Yes No Drugs, medicines, (including Aspirin)
Please list:_____
_____

Yes No Tobacco in any form
Yes No Alcohol

WOMEN ONLY:

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

ALL PATIENTS:

Yes No Do you have or have 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 medications I understand that the information regarding my medical and dental history will be confidential and information will be released to other parties only after my consent is given, except when required by State or Federal laws.

Patient Signature/Responsible Party_____Date_____