MIT Health
Dental

MIT Health
Massachusetts Institute of Technology
77 Massachusetts Ave, Building E23
Cambridge, MA 02139

Dental Service Health History

Patient Name ______________________________

Preferred Name ______________________ Date of Birth ______________________

I Circle the appropriate answer (leave blank if you do not understand a question):

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?

If Yes, why? ______________________________

4. Yes No Are you being treated by a physician now? For what? ______________________
5. Yes No Have you had a problem with prior dental work?
6. Yes No Are you in pain now?
7. Yes No Are you or could you be pregnant or nursing?
8. Yes No Are you taking birth control pills?

II All patients:

9. Yes No Do you have or have you had any other disease or medical problems NOT listed on this form?

Please List ______________________________

III Have you experienced:

10. Yes No Chest pain (angina)?
11. Yes No Swollen ankles?
12. Yes No Shortness of breath?
13. Yes No Recent weight loss, fever, night sweats?
14. Yes No Persistent cough, coughing up blood?
15. Yes No Bleeding problems, bruising easily?
16. Yes No Sinus problems?
17. Yes No Difficulty swallowing?
18. Yes No Diarrhea, constipation, blood in stools?
19. Yes No Frequent vomiting, nausea?
20. Yes No Difficulty urinating, blood in urine?
21. Yes No Dizziness?
22. Yes No Ringing in ears?
23. Yes No Headaches?
24. Yes No Fainting spells?
25. Yes No Blurred vision?
26. Yes No Seizures?
27. Yes No Excessive thirst?
28. Yes No Frequent urination?
29. Yes No Dry mouth?
30. Yes No Jaundice?
31. Yes No Joint pain, stiffness?

IV Do you have or have you had:

32. Yes No Heart disease?
33. Yes No Heart attack, heart defects?
34. Yes No Heart murmurs?
35. Yes No Rheumatic fever?
36. Yes No Stroke, hardening of arteries?
37. Yes No High blood pressure?
38. Yes No Asthma, TB, emphysema, other lung diseases?
39. Yes No Hepatitis, other liver disease?
40. Yes No Stomach problems, ulcers?
41. Yes No Frequent vomiting, nausea?
42. Yes No Difficulty urinating, blood in urine?
43. Yes No HIV/AIDS?
44. Yes No Tumors, cancer?
45. Yes No Arthritis, rheumatism?
46. Yes No Eye diseases?
47. Yes No Skin diseases?
48. Yes No Anemia?
49. Yes No VD (syphilis or gonorrhea)?
50. Yes No Herpes?
51. Yes No Kidney, bladder disease?
52. Yes No Thyroid, adrenal disease?
53. Yes No Diabetes?

V Do you have or have you had:

54. Yes No Psychiatric care?

55. Yes No Radiation treatments?

56. Yes No Chemotherapy?

57. Yes No Prosthetic heart valve?

58. Yes No Artificial joint?

59. Yes No Hospitalization?

60. Yes No Blood transfusions?

61. Yes No Surgeries?

62. Yes No Pacemaker?

63. Yes No Contact lenses?

VI Are you taking:

64. Yes No Recreation drugs?

65. Yes No Drugs, medications, over-the-counter medicines (including aspirin), natural remedies?

66. Yes No Tobacco in any form?

67. Yes No Alcohol?

Please list ______________________________

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 medication

Patient's Signature ______________________________ Date ______________