Lauren Yasuda Rainey, DDS, Inc.
General Dentistry
2519 Ashby Avenue, Berkeley, CA 94705
www.BerkeleyDentalOffice.com

Confidential Health History

First Name: _____ Last Name: _____ Date of Birth: _____

I. General Health.

Is your general health good? ☐ Yes ☐ No

If NO, explain: _____

Has there been a change in your health within the last year? ☐ Yes ☐ No

If YES, explain: _____

Have you gone to the hospital or had a serious illness in the last three years? ☐ Yes ☐ No

If YES, explain: _____

Are you being treated by a physician now? ☐ Yes ☐ No

If YES, explain: _____

Are you in pain now? ☐ Yes ☐ No

If YES, explain: _____

II. Have you been treated for any of the following?

Yes	*No*		*Yes*	*No*		*Yes*	*No*	
☐	☐	Bleeding problems	☐	☐	Difficulty urinating	☐	☐	Jaundice
☐	☐	Blood in stool	☐	☐	Dizziness	☐	☐	Joint pain or stiffness
☐	☐	Blood in urine	☐	☐	Dry mouth	☐	☐	Night Sweats
☐	☐	Blurred vision	☐	☐	Excessive thirst	☐	☐	Persistent cough
☐	☐	Bruise easily	☐	☐	Fainting spells	☐	☐	Recent weight loss
☐	☐	Chest pain (angina)	☐	☐	Fever	☐	☐	Ringing in ears
☐	☐	Coughing up blood	☐	☐	Frequent urination	☐	☐	Shortness of breath
☐	☐	Diarrhea or constipation	☐	☐	Frequent vomiting	☐	☐	Sinus problems
☐	☐	Difficulty swallowing	☐	☐	Headaches	☐	☐	Swollen ankles

III. Have your had or do you have any of the following?

Yes	*No*		*Yes*	*No*		*Yes*	*No*	
☐	☐	AIDS / HIV	☐	☐	Heart defects	☐	☐	Psychiatric care
☐	☐	Anemia	☐	☐	Heart disease	☐	☐	Radiation
☐	☐	Arthritis, rheumatism	☐	☐	Heart disease in family	☐	☐	Rheumatic fever
☐	☐	Artificial joint	☐	☐	Heart murmurs	☐	☐	Seizures
☐	☐	Asthma	☐	☐	Hepatitis A	☐	☐	Skin disease
☐	☐	Bladder disease	☐	☐	Hepatitis B	☐	☐	Stomach problems
☐	☐	Canker sores	☐	☐	Hepatitis C	☐	☐	Stroke

☐ ☐ Chemotherapy	☐ ☐ Herpes	☐ ☐ Surgeries
☐ ☐ Cold sores	☐ ☐ High blood pressure	☐ ☐ Thyroid disease
☐ ☐ Diabetes	☐ ☐ Hospitalization	☐ ☐ Transplants
☐ ☐ Eating disorders	☐ ☐ Kidney disease	☐ ☐ Tuberculosis
☐ ☐ Eye disease	☐ ☐ Liver disease	☐ ☐ Tumors or cancer
☐ ☐ Hardening of arteries	☐ ☐ Lung disease	☐ ☐ Ulcers
☐ ☐ Heart attack	☐ ☐ Osteoporosis	☐ ☐ Venereal disease

IV. Are you allergic or have you had a reaction to any of the following?

Yes *No*	*Yes* *No*	*Yes* *No*
☐ ☐ Aspirin	☐ ☐ Metal	☐ ☐ Valium
☐ ☐ Demerol	☐ ☐ Nitrous Oxide	☐ ☐ Vicodin
☐ ☐ Erythromycin	☐ ☐ Penicillin	☐ ☐ _____
☐ ☐ Food	☐ ☐ Percocet / Percodan	☐ ☐ _____
☐ ☐ Latex	☐ ☐ Sulfa	☐ ☐ _____
☐ ☐ Local anesthetic	☐ ☐ Tetracycline	☐ ☐ _____

V. Please list all medications you are currently taking.

1. _____	5. _____	9. _____
2. _____	6. _____	10. _____
3. _____	7. _____	11. _____
4. _____	8. _____	12. _____

VI. Women Only.

Are you or could you be pregnant? ☐ Yes ☐ No

If YES, when are you due? _____

Are you nursing? ☐ Yes ☐ No

Are you using hormonal birth control? ☐ Yes ☐ No

VII. All Patients.

Do you have any health problems not listed on this form? ☐ Yes ☐ No

If YES, explain: _____

Is there any other medical issue you would like to discuss with the dentist in private? ☐ **Yes** ☐ **No**

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The practice of dentistry involves treating the whole person. Medical consultation may be needed prior to the commencement of dental treatment in some circumstances. I authorize the dentist to contact my physician.

Physician's Name: _____

Physician's Phone Number: _____ Kaiser 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 medication. Further, I will not hold my dentist, or any other member of the 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