TOTAL HEALTH DENTISTRY
HAWAII
Trust Your Smile to Our Hands

Trevor Hartwell, DDS

Health History

Patient's Name _____

Date of Birth ___/___/____ Height _____ Weight _____

Physician's Name _____ Physician's Phone _____

Date of last visit to physician _____ Reason for visit to doctor _____

In case of emergency, contact _____ Phone #_____

Please check Yes or No for the following questions. If you are unsure of question, please do not answer.

☐Yes	☐*No*	Is a physician currently treating you?	☐Yes	☐*No*	Do you take aspirin daily?
☐Yes	☐*No*	Are you taking any medications now?	☐Yes	☐*No*	Are you on blood thinners?
☐Yes	☐*No*	List all current medications (use backside if needed)	☐Yes	☐*No*	Have you ever been told by a physician that you have a heart murmur?
☐Yes	☐*No*	Has your health changed in the last year?	☐Yes	☐*No*	Do you often feel exhausted or fatigued?
☐Yes	☐*No*	Have you lost weight without dieting in recent months?	☐Yes	☐*No*	Have you ever had any unusual reactions to dental anesthetic?
☐Yes	☐*No*	Have you ever been seriously ill or hospitalized?	☐Yes	☐*No*	Would you consider yourself holistic in your approach to health?
☐Yes	☐*No*	Do you have any artificial joints/prosthesis?	☐Yes	☐*No*	Do you have a tendency to faint?
☐Yes	☐*No*	Have you ever had surgery?	☐Yes	☐*No*	Do you have frequent headaches?
☐Yes	☐*No*	Have you ever had, received treatment for, or been suspected of having cancer?	☐Yes	☐*No*	Do you smoke or use smokeless tobacco?
☐Yes	☐*No*	Are you at high risk for AIDS?	☐Yes	☐*No*	Any other condition or disease not mentioned?
☐Yes	☐*No*	Do you bleed for a long time when you cut yourself?	☐Yes	☐*No*	Would you like to speak to the dentist privately about any problem?
		WOMEN:			
☐Yes	☐*No*	Are you pregnant or suspect you may be at this time?	☐Yes	☐*No*	Are you in or past menopause?

Have you ever been diagnosed or treated for these conditions? Please check Yes or No.

☐Yes	☐*No*	Jaundice	☐Yes	☐*No*	Anemia
☐Yes	☐*No*	Glaucoma	☐Yes	☐*No*	Hives or Skin Rash
☐Yes	☐*No*	Rheumatic Fever	☐Yes	☐*No*	Ulcers
☐Yes	☐*No*	Hepatitis	☐Yes	☐*No*	Epilepsy/Convulsions
☐Yes	☐*No*	Diabetes	☐Yes	☐*No*	Stroke
☐Yes	☐*No*	Asthma	☐Yes	☐*No*	Blood Disorders
☐Yes	☐*No*	Venereal Disease	☐Yes	☐*No*	Sinus Problems
☐Yes	☐*No*	Heart Problems	☐Yes	☐*No*	Kidney Problems
☐Yes	☐*No*	Chest Pains	☐Yes	☐*No*	Radiation Therapy
☐Yes	☐*No*	Thyroid Problems	☐Yes	☐*No*	Drug Dependency (Alcohol, etc.)
☐Yes	☐*No*	Pacemaker	☐Yes	☐*No*	Psychiatric Treatment
☐Yes	☐*No*	Tuberculosis	☐Yes	☐*No*	Obstructive Sleep Apnea
			☐Yes	☐*No*	Acid Reflux / GERD

To the best of my knowledge, all of the preceding information is complete and my answers are true and correct. If I ever have a change in my health, or if my medication changes, I will inform the dentist at the next appointment.

Signature _____ Date _____

Reviewed by: