Office of Dr. Gene J. Pak

Health History Form

30131 Town Center Drive, Suite 166
Laguna Niguel, CA 92677 (949) 495-3667

Patient Name: Last, First Middle Initial

Birthdate: Jan / 1 / 19

SECTION A: CHECK APPROPRIATE ANSWER *(Please leave **BLANK** if you do not understand the question. If you need more space, you may write on the back.)*

1. ☐ Y ☐ N Is your general health good?
2. ☐ Y ☐ N Has there been a change in your health history within the last year?
3. ☐ Y ☐ N Have you been hospitalized or had serious illness in the last three years?
   If so, why? _____
4. ☐ Y ☐ N Are you being treated by a physician now?
   For what? _____
5. ☐ Y ☐ N Have you had problems with prior dental treatment?
6. ☐ Y ☐ N Are you in pain now?

SECTION B: HAVE YOU EXPERIENCED...?

1. ☐ Y ☐ N Chest pain (angina)?
2. ☐ Y ☐ N Swollen ankles?
3. ☐ Y ☐ N Shortness of breath?
4. ☐ Y ☐ N Recent weight loss, fever, night sweats?
5. ☐ Y ☐ N Persistent cough, coughing up blood?
6. ☐ Y ☐ N Bleeding problems, bruising easily?
7. ☐ Y ☐ N Sinus problems?
8. ☐ Y ☐ N Difficulty swallowing?
9. ☐ Y ☐ N Diarrhea, constipation, blood in stools?
10. ☐ Y ☐ N Frequent vomiting, nausea?
11. ☐ Y ☐ N Difficulty urinating, blood in urine?
12. ☐ Y ☐ N Dizziness?
13. ☐ Y ☐ N Ringing in ears?
14. ☐ Y ☐ N Headaches?
15. ☐ Y ☐ N Fainting?
16. ☐ Y ☐ N Blurred vision?
17. ☐ Y ☐ N Seizures?
18. ☐ Y ☐ N Excessive thirst?
19. ☐ Y ☐ N Frequent urination?
20. ☐ Y ☐ N Dry mouth?
21. ☐ Y ☐ N Jaundice?
22. ☐ Y ☐ N Joint pain, stiffness?

SECTION C: DO YOU HAVE OR HAVE HAD...?

1. ☐ Y ☐ N Heart disease?
2. ☐ Y ☐ N Heart attack, heart defects?
3. ☐ Y ☐ N Heart murmurs?
4. ☐ Y ☐ N Rheumatic fever?
5. ☐ Y ☐ N Stroke, hardening of arteries?
6. ☐ Y ☐ N High blood pressure?
7. ☐ Y ☐ N TB, emphysema, other lung diseases?
8. ☐ Y ☐ N Hepatitis, other liver diseases?
9. ☐ Y ☐ N Stomach problems, ulcers?
10. ☐ Y ☐ N ALLERGIES: to drugs, foods, medications?
11. ☐ Y ☐ N Family history of diabetes, heart problems, tumors?
12. ☐ Y ☐ N AIDS or ARC?
13. ☐ Y ☐ N Tumors, cancer?
14. ☐ Y ☐ N Arthritis, rheumatism?
15. ☐ Y ☐ N Eye diseases?
16. ☐ Y ☐ N Skin diseases?
17. ☐ Y ☐ N Anemia?
18. ☐ Y ☐ N VD (syphilis or gonorrhea)?
19. ☐ Y ☐ N Herpes?
20. ☐ Y ☐ N Kidney, bladder disease?
21. ☐ Y ☐ N Thyroid, adrenal disease?
22. ☐ Y ☐ N Diabetes?

SECTION D: DO YOU HAVE OR HAVE HAD...?

1. ☐ Y ☐ N Psychiatric care?
2. ☐ Y ☐ N Radiation treatments?
3. ☐ Y ☐ N Chemotherapy?
4. ☐ Y ☐ N Prosthetic heart valve?
5. ☐ Y ☐ N Artificial joint(s)?
6. ☐ Y ☐ N Hospitalization?
7. ☐ Y ☐ N Blood transfusions?
8. ☐ Y ☐ N Surgeries?
9. ☐ Y ☐ N Pacemaker?
10. ☐ Y ☐ N Contact lenses?

SECTION E: ARE YOU TAKING?

1. ☐ Y ☐ N Recreational drugs?
2. ☐ Y ☐ N Drugs, medicines, (including Aspirin)?
   Please list:
3. ☐ Y ☐ N Tobacco in any form?
4. ☐ Y ☐ N Alcohol?

_____, _____, _____, _____

SECTION F: WOMEN ONLY:

☐ Y ☐ N Are you or could you be pregnant or nursing?
☐ Y ☐ N Are you taking birth control pills?

SECTION G: ALL PATIENTS:

☐ Y ☐ N 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.

1. *Signature:* _____ *Date:* _____
2. *Revised* _____ *Date:* _____
3. *Revised* _____ *Date:* _____