TURKISH DENTAL ASSOCIATION
HEALTH HISTORY FORM

Patient's
Name :……. Surname:……
Occupation : ……. Birth Date : ……..
Country : ……..……...

1. Are you now under the care of a physician? Are you taking or have you recently taken any prescription or over the counter medicine(s)?…….
……...……
2. Please mark (X) your response to indicate if you have had any of the following diseases or problems
……...

- ☐ Cardiovascular disease
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Stomach Disorders
- ☐ Contagious Disease
- ☐ Epilepsy
- ☐ Febrile Rheumatism
- ☐ Arthritis
- ☐ Thyroid Problems
- ☐ Abnormal Bleeding
- ☐ Drug Allergies
- ☐ Sexual transmitted disease
- ☐ Hepatitis, jaundice or liver disease
- ☐ Asthma, bronchitis
- ☐ Kidney Problems
- ☐ Gastrointestinal disease
- ☐ Sinus trouble
- ☐ AIDS or HIV infection
- ☐ Osteoporosis
- ☐ Cancer /Chemotherapy / Radiation Treatment

3. Do you use tobacco (smoking, snuff, chew, bidis)? If yes, How many cigarettes do you smoke in a day?
.....
4. Are you allergic to any medicines?.....
5. Have you had radiotherapy to the head and neck region……...…….
6. Does the bleeding last long after surgery or injury? ……..……
7. Have you had a serious illness, operation, or been hospitalized? …….
8.**Women Only**
Pregnancy? If yes, number of weeks? .....
Nursing ? .....

I certify that I have read and understand the above and the information given on this form is accurate.

Signature **Date**