PATIENT INFORMATION AND HEALTH HISTORY

Patient Name: _____ Birth Date _____ Age ___

Social Security #_____ M __ F __ Married __ Single __ DL#_____

Home Ph _____ Cell Ph _____ Work Ph _____

Address_____ City _____ State ____ Zip_____

I. CIRCLE APPROPRIATE ANSWER (leave blank if you do not understand question)

1. Yes No Has there been any change in your health within the last year?
2. Yes No Are you presently being treated for any ongoing medical conditions?
   If YES, please list_____
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
   If YES, why?_____
4. Yes No Have you had problems with prior dental treatment?
5. Yes No Are you being treated by a physician now? For what? _____
   Medical doctor name / number _____

II. HAVE YOU EXPERIENCED:

6.	Yes	No	Bleeding problems?	12.	Yes	No	Hives/Rash?
7.	Yes	No	Chest Pain (angina)?	13.	Yes	No	Jaundice?
8:	Yes	No	Dizziness?	14.	Yes	No	Seizures?
9.	Yes	No	Dry mouth?	15.	Yes	No	Shortness of breath?
10.	Yes	No	Fainting spells?	16.	Yes	No	Sinus problems?
11.	Yes	No	Headaches?	17.	Yes	No	Joint pain/stiffness?

III. DO YOU HAVE OR HAVE YOU HAD:

18.	Yes	No	AIDS?	30.	Yes	No	Heart murmurs?
19.	Yes	No	Anemia?	31.	Yes	No	High blood pressure?
20.	Yes	No	Asthma, TB, emphysema, other lung diseases?	32.	Yes	No	Kidney, bladder disease?
21.	Yes	No	Arthritis, rheumatism?	33.	Yes	No	Rheumatic fever?
22.	Yes	No	Blood disease?	34.	Yes	No	Sickle Cell?
23.	Yes	No	Diabetes?	35.	Yes	No	Stomach problems, ulcers?
24.	Yes	No	Epilespy?	36.	Yes	No	Stroke, hardening of arteries?
25.	Yes	No	Eye diseases/Glaucoma?	37.	Yes	No	Thyroid, adrenal disease?
26.	Yes	No	Heart Disease?	38.	Yes	No	Tumors, cancer?
27.	Yes	No	Heart attack, heart defects?	39.	Yes	No	VD (syphilis/gonorrhea)?
28.	Yes	No	Hepatitis, other liver disease?	40.	Yes	No	Skin diseases?
29.	Yes	No	Allergies to: drugs, foods, medications, latex? _____				

IV. DO YOU HAVE OR HAVE YOU HAD:

41.	Yes	No	Artificial joints/pins/screws?	45.	Yes	No	Mental disorders?
42.	Yes	No	Chemotherapy?	46.	Yes	No	Pacemaker?
43.	Yes	No	Head injuries?	47.	Yes	No	Radiation treatments?
44.	Yes	No	Nervous disorders?	48.	Yes	No	Surgeries?

V. ARE YOU TAKING?

49.	Yes	No	Recreational drugs?	51.	Yes	No	Tobacco in any form?
50.	Yes	No	Drugs, medications, over-the-counter meds (including Aspirin, BC & Goody powder)?	52.	Yes	No	Alcohol?

Please list:_____

_____

VI. WOMEN ONLY: Are you or could you be pregnant? Yes No

VII. ALL PATIENTS: Do you have or have you 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 medication.

Patient's signature:_____Date:_____

RECALL REVIEW:

1. Patient's signature_____ Date:_____
2. Patient's signature_____ Date:_____