HEALTH /MEDICAL HISTORY

We understand that you are here for us to help you care for your teeth and gums. Medications you are taking and health problems you may have could make a difference in how we treat your dental problems. This questionnaire will become a part of your dental record and is considered "Confidential."

Name _____ Date _____ Best Phone # to reach you:
Patient's Signature_____ (___) ___ - _____ .

Are you currently under the care of a physician, physical therapist, and/or chiropractor? (circle) Yes No
If Yes, please explain _____
Date of last physical examination _____/_____/_____
Reason for last visit? _____
Physician' Name _____ Phone #_____

What medications are you currently taking (include over the counter, vitamins, and herbal supplements)?
_____ _____ _____
_____ _____ _____

Have you ever had an allergic reaction? To: (circle & identify) Medication _____
Food_____ Latex Products _____ Other _____

In the past, have you ever had to pre-medicate with an antibiotic prior to dental treatment? (circle) Yes No
In the past, have you ever had artificial joints or a heart valve replaced? (circle) Yes No When? _____

Have you ever been treated for: (circle all that apply)

Blood Pressure: High or Low	Heart Disease	Heart Valve	Heart Murmur	Stroke
Bleeding/Clotting Disease	High Cholesterol	Diabetes	Depression	Lupus
Rheumatic Fever	Hepatitis	HIV / AIDS	Fibromyalgia	Tuberculosis

Other:_____

Do you suffer from any of the following: (circle all that apply)

Seasonal Allergies	Sinus Problems	Bronchitis	Snoring	Asthma
Neuromuscular Disorder	Mental Disorder	Back Problems	Dizziness	Dry Mouth

Trouble breathing through your nose Other:_____

Have you had a serious illness, operation, or been hospitalized in the past 5 years? (circle) Yes No
If Yes, please explain: _____Date:_____

Has there been any change in your health in the past 2 years? (circle) Yes No
If Yes, please explain: _____

Do you now or have you ever used tobacco? (circle) Yes No Quit Date: ____/_____
If you currently use tobacco, are you interested in quitting? (circle) Yes No

How many alcoholic drinks do you consume a week? _____

For women: Are you pregnant or do you think you may be pregnant? (circle) Yes No