Dental Health Information

Patient Name:

What is the reason for today's visit? _____

Name of previous Dentist: _____ Telephone #: _____

Date of last exam: _____ Cleaning: _____Full mouth X-rays: _____

General Health Information

Name of Physician: _____ Telephone Number: _____

Date of last medical exam: _____How is your general health? (please circle one) Good Fair Poor

Please list all medications you are allergic to:_____

Are you under a Physician's care other than for General care? If so, describe: _____

Have you ever had a serious illness, operation or hospitalization? If so, describe: _____

_____

Please circle **YES** or **NO** for the following questions. **(leave blank if you do not understand the question)**

Have you ever Experienced:

Yes No Chest Pain (Angina)	Yes No Bleeding Problems	Yes No Joint Pain/ Stiffness
Yes No Shortness of Breath	Yes No Bruising easily	Yes No Seizures
Yes No Recent weight loss	Yes No Night sweats or Fever	Yes No Sinus problems
Yes No Blood in stool or urine	Yes No Dizziness	Yes No Frequent Vomiting
Yes No Blurred Vision	Yes No Excessive Thirst	

Do you have or have you ever had:

Yes No Heart Attack / Defects	Yes No Pacemaker	Yes No Syphilis or Gonorrhea
Yes No Heart Murmurs	Yes No Food Allergies	Yes No Herpes
Yes No Rheumatic fever	Yes No Latex Allergy	Yes No Artificial Joints:_____
Yes No Stroke	Yes No HIV or ARC	Yes No Diabetes
Yes No High Blood Pressure	Yes No Tumors, Cancer	Yes No Blood Transfusions
Yes No Tuberculosis	Yes No Chemotherapy	Yes No Contact Lenses
Yes No Hepatitis: _____	Yes No Arthritis / Rheumatism	Yes No Psychiatric Care
Yes No Kidney/Bladder Disease	Yes No Anemia	

Are you taking:

Yes No Recreational Drugs Yes No Alcohol Yes No Dietary Supplements

Yes No Tabacco in any form Yes No Diet Pills: _____

FOR WOMAN ONLY:

Yes No Are you, or could you be pregnant? Yes No Are you taking Birth Control Pills

Do you have or had any other disease not listed on this form? If so, Please list:_____

Please list all medications you are taking:_____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes in my health and/or medication.

Patient / Guardian Signature: _____ Date: _____

Reviewed by: D.D.S. Signature: _____ Date: _____