WELCOME TO OUR OFFICE

We are a health centered dental practice. Thus, we are concerned with your total well-being, not just your oral health. An essential part of our approach is a thorough health story. Please fill out the health questionnaire below completely – even if some of the questions may not seem relevant to your dental health. Thank you!

What are your hobbies or special interests? (i.e.: sports, self improvement, education) ______________________________

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Please circle either Y (yes) or N (no) as applicable.

Do you have or ever had any of the following?

Hypoglycemia, Diabetes	Y / N	Prosthetic Valves, Joints, or Implants	Y / N
Heart Attack or Heart Trouble	Y / N	Stroke	Y / N
Hay Fever, Asthma, Allergies	Y / N	Heart Murmur, Mitral Valve Prolapse	Y / N
High Blood Pressure	Y / N	Rheumatic Fever	Y / N
Circulatory Problems	Y / N	Anemia, Blood Disorder	Y / N
Hepatitis, Jaundice	Y / N	Excessive Bleeding	Y / N
Lung Problems, Tuberculosis	Y / N	Fainting, Blackouts	Y / N
Epilepsy, Seizures	Y / N	Nervous Disorders	Y / N
Blood Transfusions	Y / N	Headaches, Migraines	Y / N
Facial or Head Injuries	Y / N	Kidney Problems	Y / N
Radiation, Chemotheraphy	Y / N	Glaucoma, Eye Problems	Y / N
Malignancies, Cancer	Y / N	Ulcers, Digestive Problems	Y / N
Sinus Problems	Y / N	History of Eating Disorders	Y / N
AIDS, ARC	Y / N	Are you pregnant now?	Y / N
HIV Positive	Y / N	Other ______________________	
Arthritis or Rheumatism	Y / N	Blood Pressure ______________________	
Venereal Diseases	Y / N		

Name, phone of physician ______________________________ Date of last physical ___/___/___

Have you been hospitalized in the last two years? Y / N If yes, please explain. ______________________________

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Do you need a referral for a physician or specialist? Y / N

Do you consume alcohol or use tobacco? Y / N In what quantities? ______________________________

Have you had unfavorable reactions to any of the following? (Please circle)

Aspirin Codeine Anesthetics Xylocaine Novocaine Sedatives Penicillin Erythomycin Other antibiotics

Other Drugs ____

Please list any drugs currently being taken ____

Reason for this dental visit ____

Date of last dental visit ______________ What was done at that time? ______________________________

Have you ever been treated by a periodontist, orthodontist, or endodontist? Y / N If yes, please explain ___________

____ Date of last x-rays____/______/______

Are you happy with the appearance of your teeth? Y / N

Have you noticed any of the following?		Recurring sore in or around the mouth	Y / N
Teeth tender when chewing	Y / N	Jaw clicking or popping	Y / N
Discomfort in face, head, neck, jaw	Y / N	Loose teeth	Y / N
Food caught between teeth	Y / N	Swelling, lumps in mouth	Y / N
Bleeding or sore gums	Y / N	Do you need nitrous, oral, or IV sedation for dental visits?	Y / N
Sensitivity to sweets, hot or cold	Y / N		

Have you had any problems with previous dental treatment? Y / N If so, please explain ______________________

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The information above is correct to the best of my knowledge.

Signature____ **Date**________________

(please complete both sides)