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 history. Please fill out the health questionnaire below completely - even if some of the questions may not seem relevant to your dental health. Thank You!

HEALTH HISTORY

Physicians Name _____ Date of last exam? _____

Specialist Name_____ Date of last visit? _____

Please list any medications you are currently taking:

_____ _____

_____ _____

_____ _____

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Heart Murmur (mitral valve prolapse)	No	Yes	Heart (Problems & Treatment)	No	Yes
Anemia	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Slow-Healing Mouth Sores	No	Yes
Hepatitis, Any Form	No	Yes	Other Infections/Illnesses	No	Yes
Rheumatic Fever	No	Yes	High Blood Pressure	No	Yes
Asthma	No	Yes	Joint Replacement	No	Yes
Bone Density/Joint Problems	No	Yes	Glaucoma	No	Yes
Emphysema or other Respiratory Illnesses	No	Yes	Abnormal Bleeding from a cut	No	Yes
Abnormal Heart Condition	No	Yes	Liver Disease (Including Jaundice)	No	Yes
Kidney Disease	No	Yes	H.I.V. Infection/AIDS/Venereal Disease	No	Yes

Are you required to Pre-Medicate before dental treatment? ..... No Yes _____

Are you allergic or have you had a reaction to:

a. Local Anesthetics..... No Yes _____
b. Penicillin or other antibiotics..... No Yes _____
c. Asprin ..... No Yes _____
d. Codeine, valium or other sedatives ..... No Yes _____
e. Latex/Metal/Other _____... No Yes _____

	Changes		Changes
Sign & Date _____	Y N	Sign & Date _____	Y N
Sign & Date _____	Y N	Sign & Date _____	Y N
Sign & Date _____	Y N	Sign & Date _____	Y N
Sign & Date _____	Y N	Sign & Date _____	Y N