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!

Do you have or have you ever had any of the following: (Please circle)

Are You Taking a Blood Thinner YES/NO

Are You taking Fosomax or other Medicine for osteoporosis YES/NO

HIV Positive (Aids)	YES/NO	Stroke	YES/NO	Facial or Head Injury	YES/NO
Sexually Transmitted Diseases	YES/NO	Kidney Problems	YES/NO	Headaches/Migraines	YES/NO
Heart Attack or Heart Trouble	YES/NO	Sinus Problems	YES/NO	Radiation/Chemotherapy	YES/NO
Pacemaker	YES/NO	Epilepsy/Seizures	YES/NO	Malignancies/Cancer	YES/NO
Heart Murmur	YES/NO	Fainting/Blackouts	YES/NO	Anemia/ Blood Disorder	YES/NO
High Blood Pressure	YES/NO	Blood Transfusions	YES/NO	Glaucoma/Eye Problems	YES/NO
Rheumatic Fever	YES/NO	Excessive Bleeding	YES/NO	Ulcers/Digestive Problems	YES/NO
Diabetes/Hypoglycemia	YES/NO	Circulation Problems	YES/NO	Hepatitis/Liver Disease	YES/NO
Lung Problems/Tuberculosis	YES/NO	Are you pregnant ?	YES/NO	Other__________________________	
Hip or Joint Replacement	YES/NO	Due Date:________________			

How many alcoholic beverages do you consume per day_______ per week________

Do you use any form of tobacco products? YES/NO If yes: smoking ____ or smokeless ____

Have you experienced any complications of healing? YES/NO

Anxiety or Depression requiring a Doctors Care or Medicine? YES/NO

Name of Medical Doctor____

Have you seen your physician or been hospitalized in the last two years? If yes please explain______________________________________

____

Have you had allergies or unfavorable reactions to any of the following? (Please Circle)

Aspirin Codeine Anesthetics Novocaine Sedatives Penicillin Antibiotics Jewelry

Latex (rubber gloves) Other Drugs/Other Allergies____

Please list any drugs currently being taken:____

____

Person to notify in case of emergency______________________________ Phone #_________________________

Phone # of nearest neighbor or relative_______________________________

<u>New Patient Dental History</u>

YES	NO	
____	____	Have you or a member of your immediate family ever been seen here before? If so how long since your/their last visit_____
____	____	Do you have any growths or sore spots in your mouth
____	____	Do you have pain in or near your ears
____	____	Do you have pain when you bite
____	____	Does food wedge between your teeth
____	____	Do your gums bleed when you brush
____	____	Have you had dental x-rays within 2 years? If so, who made them____
____	____	Have you had any unhappy dental experiences
____	____	Do you presently wear either dentures or partials
____	____	If so, are they 5 years old or older
____	____	Have you ever had a problem with a dentist or medical doctor that led to legal action
____	____	Any other pertinent information____
____	____	Can you come for an appointment on short notice

The information above is correct to the best of my knowledge, and should this information change, it is my responsibility to bring it to the attention of this office. Any work to be done on you or your children must be mutually agreed upon, and your signature indicates consent.

Date:_______________________________ Signature:____