DENTAL MEDICAL HISTORY

Patient Name _____

Dental Record Number :_____ Address _____

Patient, parent, or guardian for children, please answer all questions below. Your health history will help the dentist to give the best possible care.

Tel. No. (Home) _____ (cell) _____

Birth Date _____

Payment Source _____

Social Security No. _____

HEALTH QUESTIONNAIRE

1	Do you have now or have ever had any major medical problem?	**YES NO**
2	Are you now, or have recently been taking any drugs or medicine? If yes, please list:	**YES NO**
3	Are you allergic or sensitive to any drugs, foods, or medicine (e.g., penicillin, Aspirin xylocaine, etc.)?	**YES NO**
4	Do you have any difficulty with bleeding or healing from cut, wound, or tooth extraction?	**YES NO**
	Do you have frequent nose bleeds or bruise easily?	**YES NO**
5	Have you been hospitalized?	**YES NO**
	For what condition and for how long?	

6 Do you have or have you ever had any of the following (Circle where appropriate):

Heart Murmur/ Rheumatic Fever	**YES**	**NO**	Thyroid Problems	**YES**	**NO**
Heart disease/ heart surgery	**YES**	**NO**	AIDS/ARC/HIV infection	**YES**	**NO**
Heart Attack	**YES**	**NO**	Sinus Problems/Hay Fever	**YES**	**NO**
Angina or chest pain	**YES**	**NO**	Epilepsy / Seizures	**YES**	**NO**
Hypertension (high blood pressure)	**YES**	**NO**	Allergies : Food or Drugs	**YES**	**NO**
Nervous Disorders/Anxiety /Depression	**YES**	**NO**	Stroke	**YES**	**NO**
Anemia (thin blood) or any blood diseases	**YES**	**NO**	Diabetes/ Family History	**YES**	**NO**
Hip/Knee/joint replacement or pins	**YES**	**NO**	Fainting or dizziness	**YES**	**NO**
Lung problems (TB, Pneumonia, Asthma)	**YES**	**NO**	Inflammatory Arthritis	**YES**	**NO**
Liver problems (hepatitis,juandice, cirrhosis)	**YES**	**NO**	Tumors or Growths	**YES**	**NO**
Stomach or intestinal problems (ulcer)	**YES**	**NO**	Skin diseases or problems	**YES**	**NO**
Kidney problems (infections, dialysis)	**YES**	NO	Sexually transmitted disease	**YES**	**NO**

	Do you have now or have you ever had any other diseases not mentioned above ?	**YES NO**
7	Are you now or have you recently been under the care of a physician ?	**YES NO**
	Name of M.D. Address	
8	When did you have your last physical examination?	
9	Have you experience a recent rapid loss or gain in weight or appetite?	**YES NO**
10	WOMEN ONLY : Are you Pregnant Now? **if yes No. of Months?**	**YES NO**
	Are you taking birth control pills?	**YES NO**
11	When was your last dental visit? _____last Set of X-rays _____	**YES NO**
	For Children Only: Does your child suck his/her thumb or finger?	**YES NO**

I certify that this health history is correct and I consent for the patient named above to be treated.

Your signature (patient , parent , or guardian) _____Date_____

Summary of Findings & Precautions _____

Reviewed by _____ Date _____

rev. 05-02-2018