

HEALTH HISTORY

The following information is very important and will aid us in caring for your dental needs.

CIRCLE

CIRCLE

1. Are you having pain or discomfort at this time.....YES NO
 2. Have you ever fainted in a dental office?YES NO
 3. Have you had a serious accident or head injuryYES NO
 4. Have you been a patient in the hospital during the past two years?YES NO
For what reason? _____
 5. Do you smoke or chew tobacco.....YES NO
 6. Have you been under the care of a medical doctor during the past two years? YES NO
 7. Name of Physician _____
Address _____ Phone _____
 8. Have you taken any prescription medication or drugs during the past two years? YES NO
 9. Are you now taking any medication, drugs or pills?..... YES NO
If yes, please list: _____
 10. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance?..... YES NO
If yes, please list: _____
 11. Indicate which of the following you have had or have at present. Circle "Yes" or "No" to each item.....
- | | | |
|--|--|--|
| Heart Failure.....YES NO | Cough.....YES NO | Hepatitis B.....YES NO |
| Heart Disease or Attack.....YES NO | Tuberculosis (TB).....YES NO | Hepatitis (other).....YES NO |
| Angina Pectoris.....YES NO | Asthma.....YES NO | Liver Disease.....YES NO |
| High Blood Pressure.....YES NO | Hay Fever.....YES NO | Yellow Jaundice.....YES NO |
| Mitral Valve Prolapse.....YES NO | Sinus Trouble.....YES NO | Blood Transfusion.....YES NO |
| Heart Murmur.....YES NO | Allergies or Hives.....YES NO | Alcohol or Drug Addiction.....YES NO |
| Rheumatic Fever.....YES NO | Diabetes.....YES NO | Hemophilia.....YES NO |
| Congenital Heart Lesions.....YES NO | Thyroid Disease.....YES NO | Venereal Disease
(Syphilis, Gonorrhea).....YES NO |
| Scarlet Fever.....YES NO | Radiation Therapy.....YES NO | Cold Sores / Fever Blisters.....YES NO |
| Artificial Heart Valve.....YES NO | Chemotherapy (Cancer, Leukemia).....YES NO | Epilepsy or Seizures.....YES NO |
| Heart Pacemaker.....YES NO | Arthritis.....YES NO | Fainting or Dizzy Spells.....YES NO |
| Heart Surgery.....YES NO | Rheumatism.....YES NO | Nervousness.....YES NO |
| Artificial Joints (Hip, Knee).....YES NO | Cortisone Medicine.....YES NO | Depression.....YES NO |
| Anemia.....YES NO | Anticoagulant Medicine.....YES NO | Psychiatric Treatment.....YES NO |
| Stroke.....YES NO | Glaucoma.....YES NO | Sickle Cell Disease.....YES NO |
| Kidney Trouble.....YES NO | Pain in Jaw Joints.....YES NO | Bruise Easily.....YES NO |
| Ulcers.....YES NO | A.I.D.S.YES NO | Allergies to Jewelry.....YES NO |
| Cosmetic Surgery.....YES NO | HIV Positive.....YES NO | |
| Emphysema.....YES NO | Hepatitis A (infectious).....YES NO | |
12. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired?YES NO
 13. Do you snore?YES NO
 14. Have you been diagnosed with sleep apnea?YES NO
 15. Do you use more than 2 pillows to sleep?YES NO
 16. Have you lost or gained more than 10 lbs. in the past year? ...YES NO
 17. Do you ever wake up from sleep short of breath?YES NO
 18. Are you on a special diet?YES NO
 19. Do you bleed excessively when cut?YES NO
 20. Has your medical doctor ever said you have a cancer or tumor?YES NO
 21. Do you have any disease, condition or problem not listed?YES NO
Please describe _____

 22. Is there any other information concerning your health that we should know aboutYES NO
Please describe _____

Are you pregnant? YES NO If yes, what month? _____ Are you taking birth control pills? YES NO
Are you nursing? YES NO

Reviewed by _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I verify that the above information is true and correct to the best of my belief. I hereby authorize White Family Dental and their staff to perform for me and/or my dependents such dental treatment, medication or therapy as they deem appropriate and in connection therewith to take or prepare x-rays, models or other diagnostic aids. I acknowledge that the performance of dental services (especially the use of anesthetic) inherently involves some risk.

Patient _____ Date _____

Parent or Responsible Party _____ Relationship to Patient _____