Date:

HEALTH HISTORY

Future Dentistry

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Dental Information	
Reason for today's visit: ☐ Exam ☐ Emergency ☐ Consultation Are you in pain? ☐ Yes ☐ No	
Previous doctor:	
Date of last dental exam:	**Date of last x-ray:**

PERSONAL HEALTH HISTORY

Circle Below- If you have or had any of the following disease or medical conditions			
Alcohol/ Drug Abuse	Emphysema	Joint Problem	Stomach Ulcers
Aggressive Steroid therapy	Epilepsy	Kidney Problem	Stroke
Anemia	Fainting/ Seizures	Leukemia	Tuberculosis (TB)
Artificial Bones/ Joints	Frequent Headaches	Liver Problems	Venereal Disease
Artificial Valves	Frequent Neck Pain	Lupus	High Cholesterol
Asthma	Glaucoma	Mitral Valve Prolapse	OTHER:
Bleeding Problems	Heart Attack	Osteoporosis	
Cancer	Heart Disease	Pacemaker	
Chemotherapy	Heart Murmur	Psychiatric Problems	
Chest Pain	Heart Surgery	Rheumatic Fever	
Congenital Heart Defect	Hepatitis	Rheumatoid Arthritis	
Defibrillator	High Blood Pressure	Scarlet Fever	
Diabetes	HIV/ AIDS/ ARC	Sinus Problems	
Difficulty Breathing	Jaw Problems (TMJ)	Stents/ Shunts	
Allergies to medications			
Name the Drug	Reaction You Had		

Do you have any allergies to LATEX, FOOD or ANY DRUGS?

Please List:

MEDICAL HISTORY				
Physician	Doctor Name:			
	Office Name:			Office Number:
	Are you under any medical treatment?	☐ Yes	☐ No	
	Are you taking any medications including prescription medication?	☐ Yes	☐ No	
	Please List Medication			
	Are you taking any of the following medicine?			
	Fosamax Didrone Boniva Areida Actonel Skiled Zometa			
	Have you had any surgeries?	☐ Yes	☐ No	
	Do you drink alcohol?	☐ Yes	☐ No	
	How many drinks per week?			
	Do you smoke?	☐ Yes	☐ No	
	How much do you smoke?			
	How long have you smoked for?			
For Women	Are you pregnant	☐ Yes	☐ No	
	Do you use birth control? ☐ Yes	☐ NO		
	Are you Nursing?			

PLEASE NOTE

X-RAYS- We take pride ourselves in delivering the highest standard of care; therefor complete diagnostic x-rays are necessary. We require series of x-ray son our new patients. <u>If you have had this series in the past THREE YEARS we ask that you bring them with you on your initial visit.</u>		
Notice to test blood. A law was enacted in Virginia 1989 which authorized health care providers to test their patients for HIV antibodies when the health care provider is ACCIDENTALLY EXPOSED to blood or body fluids in a manner which may transmit the human immunodeficiency virus (HIV) However, you would be informed before any of your blood would be tested for HIV antibodies. The testing would be explained and you would be given the opportunity to ask any questions you might have. In addition, in the event that one of your health care providers is exposed to potentially infectious body fluids, permission is hereby granted to test my blood of infections Hepatitis B.		