Market Place Dentistry

HEALTH HISTORY

We are concerned about your total well-being, just not your oral health. An essential part of our approach is a thorough health history. Please fill out the questionnaire below as completely as you can. Thank you.

Name of Physician: ______________________________ Telephone: ____________________________________

Have you ever had or currently have:

Asthma, hay fever, sinusitis	Yes/ No	Pneumonia/aspiration	Yes/ No
Tuberculosis	Yes/ No	Chronic bronchitis	Yes/ No
Cardiovascular Disease	Yes/ No	High blood pressure	Yes/ No
Low blood pressure	Yes/ No	Irregular/rapid heartbeat	Yes/ No
Chest pain/Heart Attack	Yes/ No	Rheumatic heart disease/fever	Yes/ No
Congenital heart Disease	Yes/ No	Heart Murmur	Yes/ No
Mitral Valve Prolapse	Yes/ No	A stroke	Yes/ No
Fainting/loss of consciousness	Yes/ No	Seizures	Yes/ No
Muscle weakness/fatigue	Yes/ No	Artificial Joints/implants	Yes/ No
Bruise easily/bleed	Yes/ No	Anemia/Blood Disorders	Yes/ No
Blood Transfusion	Yes/ No	Cancer	Yes/ No
Diabetes	Yes/ No	Thyroid Problems	Yes/ No
Eye Disease	Yes/ No	Recurrent Ear Aches/infection	Yes/ No
Cleft palate/Cleft lip	Yes/ No	Injury to head, neck, jaw, teeth	Yes/ No
Ulcers or colitis	Yes/ No	Hepatitis/Liver Disease	Yes/ No
Kidney Disease	Yes/ No	Jaundice	Yes/ No
Renal Dialysis	Yes/ No	Any organ transplants/grafts?	Yes/ No
Any Surgeries?	Yes/ No	Any hospitalizations?	Yes/ No
Are you pregnant	Yes/ No	Other conditions not mentioned?	Yes/ No
Do you smoke?	Yes/ No	History of Phen-Phen/Redux?	Yes/ No
Drink Alcoholic Beverages	Yes/ No	Bisphosphonates?	Yes/ No
Allergy to Penicillin	Yes/ No	Allergy to Sulfa Drugs	Yes/ No
Allergy to Dental Anesthetic	Yes/ No	Allergy to Latex	Yes/ No

Any other Allergies? (Please list)____

Please list all Prescription and Non-prescription drugs taken within the past three months:

1.____________________________ 2.________________________________ 3.____________________________

Any problems from previous dental care	Yes/ No	If "Yes" please explain____________________	
Swelling or lumps in or around the mouth	Yes/ No	Are you in pain?	Yes/ No
Sensitivity to hot or cold?	Yes/ No	Clicking of jaw joint/TMJ	Yes/ No
Clenching/grinding	Yes/ No	Bleeding /infected gums	Yes/ No
Bad taste in the mouth/odor	Yes/ No	Problems with Local Anesthetic	Yes/ No
Are you interested in improving your smile?	Yes/ No		

Date of Last Dental Exam: ________________________Date of Last dental X-rays? ___________________________

I have read and understood the above questionnaire and have answered all questions truthfully to the best of my ability. If my health or medications change, I will inform my doctor at my next appointment.

____Date________________________________

Signature of Patient/Responsible Party/Conservator