WEST DENTAL CARE

HEALTH HISTORY

DATE: _____/_____/_____

Patient First Name MI Last Name

Age Height (feet-inches) Weight(lbs) Primary phone# Gender

M F

In case of an emergency. contact (person)

When was your last visit to a dental office? / / When were your last dental x-rays taken? / / Are those x-rays available? Y N

Current Physician's Name Current Physician's Phone # -

Address Suite#

City State Zip Code

1	Is your general health good?		Y		N					
2	Has there been a change in your health within the last 5 years?		Y		N					
3	Have you been hospitalized or had a serious illness in the last year?		y		N					
	If yes why?									
4	Are you being treated by a physician now? For what?		Y		N					
5	Date of last medical exam?_____/_____/_____ Date of last dental exam?_____/_____/____									
	Have you experienced:									
6	Chest pain (angina)?		Y		N	17	Dizziness?		Y		N
7	Swollen ankles?		Y		N	18	Ringing in ears?		Y		N
8	Shortness of breath?		Y		N	19	Headaches?		Y		N
9	Recent weight loss, fever, night sweats?		Y		N	20	Fainting, spells?		Y		N
10	Persistent cough, coughing up blood?		Y		N	21	Blurred vision?		Y		N
11	Bleeding problems, bruising easily?		Y		N	22	Seizures?		Y		N
12	Sinus problems?		Y		N	23	Excessive thirst?		Y		N
13	Difficulty swallowing?		Y		N	24	Frequent urination?		Y		N
14	Diarrhea, constipation ,blood in stools?		Y		N	25	Dry mouth?		Y		N
15	Frequent vomiting, nausea?		Y		N	26	Jaundice?		Y		N
16	Difficulty urinating, blood in urine?		y		N	27	Joint pain, stiffness?		Y		N
	Do you have or have you had:									
28	Heart disease?		Y		N	39	AIDS?		Y		N
29	Heart attack, Heart defects?		Y		N	40	Tumors, Cancer?		Y		N
30	Heart murmurs?		Y		N	41	Arthritis, rheumatism?		Y		N
31	Rheumatic fever?		Y		N	42	Eye diseases?		Y		N
32	Stroke, hardening of arteries?		Y		N	43	Skin diseases?		Y		N
33	High blood pressure?		Y		N	44	Anemia?		Y		N
34	Asthma,TB,Emphysema,other lung disease?		Y		N	45	VD (syphilis or gonorrhea)?		Y		N
35	Hepatitis, other liver disease?		Y		N	46	Herpes?		Y		N
36	Stomach problems, ulcers?		Y		N	47	Kidney, bladder disease?		Y		N
37	Allergies to drugs, foods, medications, latex		Y		N	48	Thyroid, adrenal disease?		Y		N
38	Family history of diabetes, heart problems, tumors		Y		N	49	Diabetes?		Y		N
	Do you have or have you had:									
50	Psychiatric care?		Y		N	55	Hospitalization?		Y		N
51	Radiation treatments?		Y		N	56	Blood Transfusion?		Y		N
52	Chemotherapy?		Y		N	57	Surgeries		Y		N
53	Prosthetic heart valve?		Y		N	58	Pacemaker?		Y		N
54	Artificial joint?		Y		N	59	Contact lenses?		Y		N
	Are you taking:									
60	Recreational drugs?		Y		N	70	Antibiotics or sulfa drugs		Y		N

61	Alcohol?		Y		N	71	Have you taken the diet medication Redux (Fen-Phen)?		Y		N
62	Tobacco in any form?		Y		N	72	Cortisone / Prednisone (steroids		Y		N
63	Medicine for high blood pressure		Y		N	73	Sedatives		Y		N
64	Antidepressants		Y		N	74	Aspirin		Y		N
65	Antihistamines		Y		N	75	Digitalis or drugs for heart trouble		Y		N
66	Insulin, tolbutamide (orinase) or similar		Y		N	76	Oral contraceptives or other hormonal therapy		Y		N
67	Nitroglycerin		Y		N	77	Herbal remedies (Describe below)		Y		N
68	Medicine for osteoporosis: Fosamax, Aredia, Boniva, Zometa (Bisphosphonates)		Y		N	78	Any other drug or medicine?		Y		N
69	Anticoagulants (blood thinners)		Y		N	79	NONE		Y		N
Are you allergic or have you reacted adversely to any of the following?											
80	Local anesthetics		Y		N	87	Cortisone / Prednisone (steroids)		Y		N
81	Medicine for high blood pressure		Y		N	88	Barbiturates, sedatives or sleeping pills		Y		N
82	Sulfa drugs		Y		N	89	Iodine		Y		N
83	Aspirin		Y		N	90	Nickel or other metals		Y		N
84	Codeine or other narcotics		Y		N	91	Other allergies		Y		N
85	Latex		Y		N	92	NONE		Y		N
86	Penicillin or other antibiotics		Y		N						
Women only:											
93	Are you or could you be pregnant or nursing?		Y		N	94	Taking birth control pills?		Y		N
All patients:											
95	Do you have or have you had any other diseases or medical problems NOT listed on this form?								Y		N
96	If so please explain:										
97	Do any of your teeth hurt?		Y		N	102	Does your jaw click or pop?		Y		N
98	Do your gums bleed or hurt?		Y		N	103	Is there anything about your teeth or smile that you would like to change?		Y		N
99	Are any of your teeth sensitive ?		Y		N	104	Do you wear a partial denture, full denture or any other removable dental appliance?		Y		N
100	Does food get caught in your teeth?		Y		N	105	Is there anything about your partial denture, full denture or any other removable dental appliance that you would like to change		Y		N
101	Do you clench or grind your teeth?		Y		N	106	Have you experienced any pain or soreness in the muscles of your face or around your ear?		Y		N
Do you have?											
107	Frequent headaches		Y		N	109	Shoulder aches		Y		N
108	Neck aches		y		N	110	NONE		Y		N

Additional comments & descriptions

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I hereby certify that I have read the foregoing and filled out this questionnaire completely. I have advised you of all medical problems of which I am aware. I further certify that I, the unsigned, consent to the performing of x-rays and examination.

Signature of PATIENT or GUARDIAN_ _____Date _____/_____/_____

UPDATES

Have there been any changes in your medical history, including any medications that you take, since you last completed this? YES_____ NO_____

Signature of PATIENT or GUARDIAN_____Date _____/_____/_____