DENTAL HISTORY CONTINUED

Patient Name ______________________________________

☐ Anemia	☐ Arthritis	☐ Artificial heart val	☐ Artificial Joints
☐ Asthma	☐ Blood Disease	☐ Cancer	☐ Cold Sores
☐ Diabetes	☐ Dizziness	☐ Emphysema	☐ Epilepsy
☐ Excessive Bleeding	☐ Fainting	☐ Glaucoma	☐ Head Injuries
☐ Heart Attack	☐ Heart Disease	☐ Heart Murmur	☐ Hemophilia
☐ Hepatitis A B or C	☐ High Blood Pressure	☐ HIV	☐ Jaundice
☐ Kidney Disease	☐ Liver Disease	☐ Mental Disorders	☐ Nervous Disorders
☐ Pacemaker	☐ Pregnancy	☐ Radiation Treatment	☐ Respiratory Problems
☐ Rheumatic Fever	☐ Rheumatism	☐ Sickle Cell Disease	☐ Sinus Problems
☐ Special Diet	☐ Stomach Problems	☐ Stroke	☐ Thyroid Disease
☐ Tuberculosis	☐ Tumors	☐ Ulcers	☐ Venereal Disease

Have you lost or gained more than 10 pounds in the past year? Yes No
Do you have any disease , condition or problem not listed ? Yes No
If yes, please explain______________________________________
Are you on a special diet? Yes No
WOMEN...are you pregnant or think you could be? Yes No
If yes how many months__________Nursing ? Yes No
Do you use birth control pills? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should furthur information be needed, you have my permission to ask my healthcare provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature________________________________Date__________________