Goodall
FAMILY DENTISTRY

Health History

Answers to the following questions are for our records only and will be considered confidential.

Patient Name: (Please print clearly) _____

Allergies: **DDS Reviewed**:_____

Aspirin	Yes	No
Codeine	Yes	No
Latex	Yes	No
Penicillin	Yes	No
Sulfa	Yes	No
Local Anesthetic	Yes	No
Other: _____		

Medications:

Bisphosphanate (Fosemax)	Yes	No
Vitamins or Herbs	Yes	No
Have you taken Redux or Pondimin (FenPhen)?	Yes	No
Do you take birth control?	Yes	No

[ ] I do not take any medications. Initials: _____

[ ] I take additional medications that I have not listed next to conditions below:

_____

_____

_____

Please indicate if you have or had any of the following conditions. Please circle. If Yes, list medication and explain in space below:

				Medications or additional information:
Heart:	Heart Attack	Yes	No	_____
	Heart Stent Placed	Yes	No	_____
	Mitral Valve Prolapsed	Yes	No	_____
	Heart Disease	Yes	No	_____
	Heart Failure	Yes	No	_____
	Angina Pectoris	Yes	No	_____
	Heart Surgery	Yes	No	_____
	Heart Murmur	Yes	No	_____
	Pace Maker	Yes	No	_____
	Congenital Heart Problems	Yes	No	_____
	Congestive Heart Failure	Yes	No	_____
	Rheumatic Fever	Yes	No	_____
Blood:	Hepatitis A	Yes	No	_____
	Hepatitis B	Yes	No	_____
	Hepatitis C	Yes	No	_____
	Hepatitis D	Yes	No	_____
	Hepatitis E	Yes	No	_____
	Blood Transfusions	Yes	No	_____
	HIV, AIDS, ARC	Yes	No	_____
Liver Disease		Yes	No	_____
Kidney Trouble		Yes	No	_____
Thyroid Disease		Yes	No	_____
High or Low Blood Pressure		Yes	No	_____
Anemia		Yes	No	_____
Diabetes		Yes	No	_____
Epilepsy/Seizures		Yes	No	_____
Arthritis		Yes	No	_____

(Turn Over to Complete)

Stroke	Yes	No	_____
Epilepsy/Seizures	Yes	No	_____
Fainting/Dizziness	Yes	No	_____
Artificial Joints	Yes	No	_____
Cancer: Type & Treatment	Yes	No	_____
Steroid Treatment	Yes	No	_____
Eyes: Glaucoma	Yes	No	_____
Sinus Problems or Surgery	Yes	No	_____
Psychiatric Treatment	Yes	No	_____
Eating Disorders	Yes	No	_____
Parkinson's Disease	Yes	No	_____
Alzheimer's Disease	Yes	No	_____
Dementia	Yes	No	_____

Lungs:

Smoking	Yes	No	_____
Emphysema	Yes	No	_____
Persistent Cough	Yes	No	_____
Asthma	Yes	No	_____
Tuberculosis	Yes	No	_____
Recreational Drugs	Yes	No	_____
Alcoholism	Yes	No	_____
GERD	Yes	No	_____

Female: Pregnant Yes No

Dental:

Implants	Yes	No
Dentures or Partials	Yes	No
Cold Sores	Yes	No
Clicking or popping	Yes	No
Pain in or around your ears	Yes	No
Difficulty opening or closing	Yes	No
Difficult chewing	Yes	No
Teeth Loose	Yes	No
Bad Breath	Yes	No
History of trauma to jaw or face	Yes	No
Collect food between teeth	Yes	No
Have you been diagnosed with TMJ/TMD	Yes	No
Clenching or Grinding	Yes	No
Sensitive Teeth	Yes	No

1. Have you seen a Periodontist?	Yes	No
2. Name of Periodontist:_____		
3. Have you or any other member of your family been seen by us before?	Yes	No
4. If yes, Which family member(s)?_____		
5. Date of last physical exam:_____		
6. Physician's Name:_____		
7. Date of last dental exam:_____		
8. Date of last dental x-rays:_____		
9. Previous Dentist's Name:_____		
10. City/State location of previous Dentist:_____		
11. Do you have any pain or discomfort at this time?	Yes	No
12. Do you feel nervous about having dental treatment?	Yes	No
13. Have you ever had a bad experience in a dental office?	Yes	No
14. Is there anything you dislike about your smile?	Yes	No
15. Is there anything you would like to speak with the Doctor about in private?	Yes	No
16. Have you been a patient in the hospital during the past 2 years?	Yes	No
17. Have you been under the care of a medical Doctor during the past 2 years?	Yes	No

Patient Signature:_____**Date**:_____