VITEK FAMILY DENTISTRY, P.C. ▪ ALEXA M. VITEK D.D.S. ▪ 13173 SCHAVEY ROAD ▪ DEWITT, MI 48820 ▪ 517-277-2000

HEALTH HISTORY

PERSONAL

First Name_____ Last Name_____ MI_____ M / F

Preferred Name/Nickname (if any)_____ Date of Birth_____

MEDICAL HISTORY

Do you consider yourself to be in good health? Yes No

Have you been hospitalized or had a serious illness/injury within the last year? Yes No
If yes, please explain_____

Women Only: Are you currently: Pregnant/trying to get pregnant? Yes No Nursing? Yes No

Do you have, or have you had, any of the following? *Please circle (Y) Yes or (N) No*

Abnormal Bleeding	Y	N	Epilepsy or Seizures	Y	N	Pacemaker	Y	N
Alzheimer's Disease	Y	N	Fainting/Dizziness	Y	N	Psychiatric Care	Y	N
Anemia	Y	N	Frequent Cough	Y	N	Radiation Treatments	Y	N
Angina	Y	N	Heart Attack/Failure	Y	N	Renal Dialysis	Y	N
Artificial Heart Valve	Y	N	Heart Disease	Y	N	Shingles	Y	N
Artificial Joint	Y	N	Heart Murmur	Y	N	Sickle Cell Disease	Y	N
Asthma	Y	N	Hepatitis	Y	N	Sinus Trouble	Y	N
Blood Disorder	Y	N	High Blood Pressure	Y	N	Stroke	Y	N
Cancer	Y	N	HIV+/AIDS	Y	N	Thyroid Disease	Y	N
Chemotherapy	Y	N	Hypoglycemia	Y	N	Tuberculosis	Y	N
Chest Pains	Y	N	Irregular Heartbeat	Y	N	Tumors or Growths	Y	N
Cold Sores/Fever Blisters	Y	N	Kidney Problems	Y	N	Blindness	Y	N
Congenital Heart Disorder	Y	N	Liver Disease	Y	N	Other: _____		
Diabetes	Y	N	Methemoglobinemia	Y	N			

If you answered *yes* to any of the above, please explain:_____

_____

Please list any medications you are currently taking (including over-the-counter, vitamins, natural remedies):

_____

Are you allergic to any of the following? *(please circle)* Penicillin Codeine Erythromycin Latex Local Anesthetics

Metals Tetracycline Acrylic Foods Sulfa Bisulfites Other_____

If you answered *yes* to any of the above, please explain the reaction that occurs_____

Do you use recreational drugs? Yes No Do you smoke? Yes No

Do you use chewing tobacco? Yes No Are you interested in quitting? Yes No

DENTAL HISTORY

Please list any complications associated with previous dental treatment:_____

Have you been told by a physician or previous dentist that you require antibiotics prior to dental treatment? Yes No

Do you have or have you ever experienced pain in your jaw joint (TMJ/TMD) Yes No

Have you been told you have periodontal (gum) disease? Yes No

How often do you floss? Daily Occasionally Never Do you brush at least twice per day? Yes No

I certify that I have read and understood the information on this form. The questions have been accurately answered to the best of my knowledge. I understand that providing incorrect or incomplete information can be dangerous to my health. It is my responsibility to inform the dentist and staff of any changes to my health or medical status.

_____ _____

PATIENT SIGNATURE **DATE**