Robert C. Todd, DMD
Patient Health History

Name: ____ Date:_________________________

The following health history is designed to help us provide you with the best dental care possible. Please assist us by answering all questions as accurately as possible.

Medical History

YES NO 1. Have there been any significant changes in your health in the past year? If so, please explain____

YES NO 2. Are you currently of have you taken any medication within the last six weeks? If so, please list the medicine and it's dosage. ____________________________

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YES NO 3. Have you ever had an unusual or allergic reaction to any drug or medication (including dental anesthetic, penicillin, aspirin, codeine, or others)? If so, please explain____

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YES NO 4. Do you bleed a long time when you are cut or after having a tooth extracted?

YES NO 5. Have you or any members of your immediate family ever had tuberculosis? If so, who? ____

YES NO 6. Have you or any members of your immediate family ever had hepatitis or liver disease? If so, who? ____

YES NO 7. Have you ever been treated for the HIV (Aids) virus?

YES NO 8. Have you ever been told that you cannot donate blood? If so, why?____

YES NO 9. Have you ever been told that you need to take penicillin or some other antibiotic prior to dental treatment? If so, why? ___________________________

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YES NO 10. Do you have excessive urination or thirst?

YES NO 11. (Children) Are your immunizations current?

YES NO 12. (Women) Are you pregnant? If so, how many months ____________________

YES NO 13. Have you ever had any of the following: (check all that apply)

_______ High / Low Blood Pressure
_______ Rheumatic Fever
_______ Arthritis
_______ Stroke
_______ Persistent Cough
_______ Venereal Disease
_______ Epilepsy
______ Radiation treatments
______ Diabetes (sugar)
______ Heart Trouble
______ Emphysema
______ Glaucoma
______ Asthma

14. Name of physician ___________________________________

Address ____

____

Telephone number____________________________________

Dental History

1. What is the reason for your visit? ____________________

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2. When was your last dental visit? ____________________

YES NO 3. Do your gums bleed when you brush or floss your teeth?

YES NO 4. Are any of your teeth sensitive to temperature or sweets?
If so, which ones ____________________

YES NO 5. Do you have any difficulty chewing your food? If so, please explain

____

YES NO 6. Have you noticed any loosening of your teeth? If so, which ones?

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YES NO 7. Do your jaws pop or lock when opening your mouth? If so, please explain

____

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YES NO 8. Do you suffer from frequent headaches?

YES NO 9. Do you snore?

YES NO 10. Do you have a C-PAP machine? If so do you use it? ____________________

YES NO 11. Do you have any disease, condition or problem not listed above that I should know about? ____________________

____

YES NO 12. Would you be interested in learning some new information that would give you or your family members fresher breath?

PATIENT SIGNATURE (or guardian if under 18)

____

DATE: ____________________

If you haven't been to the office for one year or longer, please review the answers on your health history. List any changes below. Thank you for taking the time to complete this form.

DATE	CHANGES	SIGNATURE