Health History

Name:_____ Date: _____

Address: _____City:_____ State: _____ Zip: _____

Phone: Home: _____ Cell:_____ Work: _____

Email: _____ Marital Status: Married: _____ Single _____ Other: _____

Male: _____ Female: ____ Date of Birth: _____ Age:_____ Social Security # _____

ARE YOU A SEASONAL RESIDENT? ____Yes ____No

How did you hear about our office: (Please check One) VIPcare Office: _____

(___) Friend/Relative _____ (___) Internet (___) Insurance Co._____ (___) OTOW Newsletter

Date of last health care exam: _____ Date of last dental exam _____ Last Cleaning _____

Name, location, phone number for Preferred Pharmacy: _____

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Artificial heart valve	Yes	No	Heart attack (MI) (When) _____	Yes	No
History of infective endocarditis	Yes	No	Hypertension	Yes	No
Congenital heart conditions (birth defect):	Yes	No	Low Blood pressure	Yes	No
repaired or incompletely repaired cyanotic			Pacemaker (What Kind)_____	Yes	No
disease, prosthetic repair, remmaning defect after			Heart stent (When) _____	Yes	No
repair			Heart Bypass (When) _____	Yes	No
Cardiac Transplant with heart valve problem	Yes	No	Stroke (When) _____	Yes	No
History of prolonged use of Morphine	Yes	No	Treated for Anxiety	Yes	No
Treated for Chronic Pain Management	Yes	No	Treated for Depression	Yes	No
History of recreational drug use (confidential)	Yes	No	Treated for Psychosis	Yes	No
Organ Transplant (When)	Yes	No	Unintentional Weight Loss/Gain	Yes	No
Asthma	Yes	No	Latex Allergy	Yes	No
Diabetes	Yes	No	Joint Replacement (when?)What kind?)	Yes	No
Liver Disease	Yes	No	_____		
Kidney Disease	Yes	No	Slow-Healing Mouth Sores	Yes	No
Anemia (blood disease)	Yes	No	Abnormal Bleeding from a cut	Yes	No
Emphysema or other Respiratory Illness	Yes	No	Glaucoma	Yes	No
Epilepsy	Yes	No	Sore/Enlarged Lymph Nodes	Yes	No
HIV Positive or AIDS related complex	Yes	No	Recurrent Illness	Yes	No
Venereal Disease	Yes	No	Other Infections:	Yes	No
History of Surgery:_____	Yes	No	Cancer/Tumors __ _____	Yes	No

G.E.R.D or Gastric Reflux or Ulcer	Yes	No	Radiation or Chemotherapy	Yes	No

Are you taking any of these medications?

Premedication before dental treatment	Yes	No	Tagamet (Cimetidine)?	Yes	No
Antacids	Yes	No	Herbal Supplements?	Yes	No
Anticoagulants? Blood Thinner: _____	Yes	No	Daily Aspirin? (circle one) 81mg 325mg	Yes	No
Have you been treated with Bisphosphonate drugs? Fosamax, Boniva, or Actonel				Yes	No

Please list medications or supplements you are currently taking? (we can make a copy of your list):

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8._____
4. _____ 9. _____
5. _____ 10. _____

Have you been hospitalized in the last 5 year? (please circle) Yes No
If yes, reason:_____

Are you currently receiving medical care? Yes No If yes, nature of care: _____

Please list all the names and numbers of the physicians who are currently providing you care:

1. _____ 3. _____
2. _____ 4. _____

Woman: Are you pregnant? Yes No

Abnormal Blood Pressure? Yes No
If yes, what is it usually? S._____/D._____

Are you allergic or have you had a reaction to any of the following. Please circle and/or specify:

a. Local anesthetics……... No Yes
b. Penicillin or other antibiotics ……... No Yes
c. Aspirin …… No Yes
d. Codeine, valium or other sedatives …… No Yes
e. Other _____

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

_____ _____ _____
Patient (Print Name) Patient Signature Date

Daniel Greenstein, DDS_____ _____ _____
Dentist (Print Name) Dentist Signature Date

Dental History

How long since you have seen a dentist? _____

Are you having PROBLEMS now? Yes No If so, WHAT?_____

How would you rank your DENTAL HEALTH now? GOOD FAIR POOR

How do you FEEL about dental treatment: FINE APPREHENSIVE FEARFUL

Are your teeth SENSITIVE to hot, cold, sweet, pressure? (Please circle all that apply)

Are you aware of GRINDING or CLENCHING your teeth? Yes No

Do you have HEADACHES, EARACHES, or NECK PAINS? Yes No

Have you ever had PERIODONTAL (GUM) disease or treatments? Yes No

Do your gums BLEED, feel TENDER, or IRRITATED? Yes No

Do you have any concerns about BAD BREATH ODOR? Yes No

Do you wear DENTURES (Partials or Full) Yes No Are you UNHAPPY with your dentures? Yes No

Are you PLEASED with the APPEARANCE of your teeth when you smile? Yes No

Do you have DISCOLORED teeth that bother you? Yes No

If you could CHANGE anything about the appearance of YOUR SMILE, what would it be? _____