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ST. PETERSBURG DENTAL CENTER

Introduction & Adult Health History Sheet

IN ORDER THAT WE MAY THOROUGHLY EVALUATE YOUR DENTAL PROBLEM, YOUR KINDNESS IN FURNISHING THE FOLLOWING INFORMATION WILL BE APPRECIATED. ALL ANSWERS WILL BE HELD IN STRICT CONFIDENCE AND USED IN THE PREPARATION OF YOUR CLINICAL TREATMENT CHART.

1. PATIENT'S NAME			2. BIRTHDATE:			ADDRESS	CITY	STATE	ZIP
			Jan	1	2010			WY	
LAST	F RST	M.	MO.	DAY	YEAR				

SS #	EMAIL	HOME PHONE: CELL PHONE: WORK PHONE (PT):
EMPLOYED BY:		REFERRED BY:

SPOUSE NAME	EMPLOYED BY	SPOUSE WORK PHONE
PHYSICIANS NAME	ADDRESS	PHONE

Are you receiving treatment from a physician at the present time? ○ YES ○ NO

If so, for what?

Has a physician ever told you that you have heart trouble? ○ YES ○ NO

Have you ever been treated for high or low blood pressure? ○ YES ○ NO

Do you ever have severe heart or chest pains? ○ YES ○ NO

Have you ever had a stroke or heart attack? ○ YES ○ NO

Have you ever had rheumatic fever? ○ YES ○ NO

Do you have a prosthetic (artifical) heart valve, heart murmur or Mitral Valve Prolapse? ○ YES ○ NO

Do you hae a heart pacemaker ○ YES ○ NO

Have you ever had severe & prolonged bleeding after cuts or tooth extractions? ○ YES ○ NO

Do you take insulin or receive other treatment for diabetes? ("Sugar Disease") ○ YES ○ NO

Have you ever been treated with CORTISONE or ACTH within the past year? ○ YES ○ NO

Are you HIV Positive? ○ YES ○ NO

Do you ever have seizures or convulsions? ○ YES ○ NO

Have you ever had Hepatitis? ○ YES ○ NO

Are you allergic (sensitive) to any food or drugs? ○ YES ○ NO

If so, for what?

Are you taking any medicines at the present time? ○ YES ○ NO

If so, for what?

Do you have any prosthetic (artificial) joints? (knee, hip, etc.) ○ YES ○ NO

Have you ever had any popping, clicking or pain in your Temporamandibular Joint (TMJ)? ○ YES ○ NO

Have you ever had an allergic reaction to latex products? ○ YES ○ NO

Have you ever had surgery on X-ray treatment for a tumor, growth or other condition in your mouth or on your lips, or other areas of the body? ○ YES ○ NO

Have you ever been given general anesthetic (been put to sleep), either for oral surgery or any other type of surgery? ○ YES ○ NO

WOMEN: Are you pregnant at the present time? ○ YES ○ NO

Are you taking Birth Control Pills? ○ YES ○ NO

Have you ever had severe & prolonged bleeding after cuts or tooth extractions? ○ YES ○ NO

Have you any OTHER reason to think that you are not now in good health? ○ YES ○ NO

If so, what?

UPDATES:

Date _____ Initials _____ Date _____ Initials _____ Date _____ Initials _____

Patient's Signature _____ Date _____