WELCOME TO ROSEVILLE DENTAL ASSOCIATES!

Health History Form

Patient Information:

Name: Last_____ First _____ Middle_____ DOB: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Address: _____ City _____ State _____ Zip_____

Circle one: Single Married Widowed Divorced

Spouse Name: _____ Cell Phone: _____

Person to contact in case of emergency: _____ Relationship _____

Emergency contact info: _____

Whom may we thank for referring you? _____

Primary Physician: _____ Phone: _____

Clinic Name and location: _____

Medical Information: Please circle one and answer the following questions

Are you under medical treatment now? YES NO

Have you been hospitalized for any surgical operation or serious illness? YES NO

Are you taking any medication(s)? Including non-prescribed meds YES NO

If yes, please write all the names of medications you are taking:_____

_____

_____

Are you currently under medical treatment? If yes, please explain:

_____

Women only:

YES NO Are you pregnant or think you may be?

YES NO Are you nursing?

YES NO Are you on birth control?

Are you allergic to or have you had any reactions to the following: (circle one)

Latex YES NO	**Aspirin YES NO**
Local Anesthetic (NOVOCAINE) YES NO	**Codeine YES NO**

Penicillin/ Amoxicillin YES NO	**Sulfa drugs YES NO**
Any Other Antibtiotics YES NO	**OTHER: _____**

Please circle if you have or had any of the following in the past:

Heart Defect	**YES**	**NO**	**Heart Murmur**	**YES**	**NO**
Tuberculosis	**YES**	**NO**	**Lung Disease**	**YES**	**NO**
Tumors	**YES**	**NO**	**Asthma**	**YES**	**NO**
Vision Problems	**YES**	**NO**	**Osteoporosis/Osteopenia**	**YES**	**NO**
Rheumatic Fever	**YES**	**NO**	**Hepatitis A, B or C**	**YES**	**NO**
Jaundice	**YES**	**NO**	**Sinus Problems**	**YES**	**NO**
Radiation Therapy	**YES**	**NO**	**High Blood Pressure**	**YES**	**NO**
Low Blood Pressure	**YES**	**NO**	**Ulcers**	**YES**	**NO**
Epilepsy, Seizures	**YES**	**NO**	**Joint Replacement**	**YES**	**NO**
Stroke	**YES**	**NO**	**Diabetes I or II (circle one)**	**YES**	**NO**
Fainting Spells	**YES**	**NO**	**Venereal Disease**	**YES**	**NO**
Abnormal Bleeding	**YES**	**NO**	**Chemical Dependency**	**YES**	**NO**
Arthritis	**YES**	**NO**	**Heart Valve Replacement**	**YES**	**NO**
Anemia	**YES**	**NO**	**Mental Health Care**	**YES**	**NO**
HIV/AIDS	**YES**	**NO**	**Pacemaker**	**YES**	**NO**
Thyroid Problems	**YES**	**NO**	**Eating Disorder**	**YES**	**NO**
Sleep Disorder	**YES**	**NO**	**Acid Reflux**	**YES**	**NO**

Dental History: Circle one please

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

Are your teeth sensitive to cold, hot, sweets or pressure YES NO

Is your mouth dry? YES NO

Have you had any periodontal (gum) treatments YES NO

Have you ever had orthodontic (braces) treatment? YES NO

Are you currently experiencing dental pain or discomfort? YES NO

Do you have earaches or neck pains: YES NO

Do you have any clicking, popping or discomfort in the jaw? YES NO

Do you brux or grind your teeth? YES NO

Do you have sores or ulcers in your mouth? YES NO

Do you wear dentures or partials? YES NO

Have you ever had a serious injury to your head or mouth? YES NO

What is the reason for your dental visit today?_____

Date of your last dental exam: _____

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment. I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

SIGNATURE: _____ Date: _____