WESTSIDE DENTAL GR

HEALTH HISTORY

Name _____ Birth Date_____ Email_____

Address_____Phone_____

Have you been hospitalized in the last 5 years? No Yes If yes, reason: _____

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

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

_____

Abnormal Bleeding from a cut	No	Yes	**Joint Replacement (How long ago?)**	No	Yes
Abnormal Heart Condition	No	Yes	Kidney Disease	No	Yes
Anemia	No	Yes	**Latex Allergy/Sensitivity**	No	Yes
Asthma	No	Yes	Liver Disease/Jaundice	No	Yes
Diabetes	No	Yes	Other Infection	No	Yes
Emphysema/Respiratory Illness	No	Yes	Previous Biopsies	No	Yes
Epilepsy/Prone to Seizures	No	Yes	Psychosis	No	Yes
Glaucoma	No	Yes	Recurrent Illnesses	No	Yes
Heart Condition(s) – Surgery, Disease, Attack	No	Yes	Rheumatic Fever	No	Yes
Heart Murmur (Mitral Valve Prolapse)	No	Yes	Slow Healing Mouth Sores	No	Yes
Hepatitis (What type?)	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
HIV Positive/AIDS Related Complex	No	Yes	Unintentional Weight Loss or Gain	No	Yes

Are you required to **Pre-Medicate** before dental treatment? **No** **Yes**

Do you have a history of abnormal blood pressure? **No** **Yes**
If yes, what is it usually?

Women:

Are you pregnant?	No	Yes
If no, are you planning a pregnancy in the near future?	No	Yes
Are you a nursing mother?	No	Yes
Are you taking birth control pills?	No	Yes

Are you allergic or have you had a reaction to:

Local anesthetics	No	Yes
Penicillin or other antibiotics	No	Yes
Aspirin	No	Yes
Codeine, valium or other sedatives	No	Yes

Please list additional allergies:

Are you a smoker? If yes, how much per day? _____ No Yes

Please list any medications you are currently taking: _____

TMD/Bruxing/Sleep Apnea Questions:

Do you snore or have been told you do?				No	Yes
Does your snoring bother others?				No	Yes
Do you clench/grind your teeth at night (Bruxism)?				No	Yes
Have you ever been diagnosed with TMD (Tempromandibular Joint Disorder)?				No	Yes
Have you even been diagnosed with Sleep Apnea?				No	Yes
How often do you feel tired after you sleep? (Circle)	Never	1-2x/month	1-2x/week	3-4x/week	Everyday
Do you regularly suffer from headaches? Frequency?	Never	1-2x/month	1-2x/week	3-4x/week	Everyday

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all 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 change in my health and medication.

_____ _____ _____

Patient/Parent Signature **Date**