

WELCOME TO OUR OFFICE

Anderson Dentalcare is a health centered practice. We are concerned with your total well-being, not just your oral health, an essential part of our approach is a thorough health history. Please fill out the health questionnaire below completely – even if some of the questions may not seem relevant to your dental health. Thank you!

Please circle either Y (yes) or N (no) as applicable.

Do you have or ever had any of the following health conditions?

Hypoglycemia, Diabetes	Y/N	Prosthetic Valves, Joints, or Implants	Y/N
Heart Attack or Heart Trouble	Y/N	Stroke	Y/N
Hay Fever, Asthma, Allergies	Y/N	Heart Murmur, Mitral Valve Prolapse	Y/N
High Blood Pressure	Y/N	Rheumatic Fever	Y/N
Circulatory Problems	Y/N	Anemia, Blood Disorder	Y/N
Hepatitis, Jaundice	Y/N	Excessive Bleeding	Y/N
Lung Problems, Tuberculosis	Y/N	Fainting, Blackouts	Y/N
Epilepsy, Seizures	Y/N	Nervous Disorders	Y/N
Blood Transfusions	Y/N	Headaches, Migraines	Y/N
Facial or Head Injuries	Y/N	Kidney Problems	Y/N
Radiation, Chemotherapy	Y/N	Glaucoma, Eye Problems	Y/N
Malignancies, Cancer	Y/N	Ulcers, Digestive Problems	Y/N
Sinus Problems	Y/N	History of Eating Disorders	Y/N
Arthritis or Rheumatism	Y/N	Women: Are you pregnant?	Y/N
AIDS/HIV Positive	Y/N	Do you use Tobacco?	Y/N
STD (Sexually Transmitted Disease)	Y/N	Chemical Dependency	Y/N

Name, phone number of physician _____ Date of last physical ___/___/___

Have you ever been hospitalized in the last two years? Y/N If yes, please explain _____

Have you had unfavorable reactions to any of the following? (Please circle)

Aspirin Codeine Anesthetics Sedatives Penicillin Erythomycin Other Antibiotics

Other Drug Allergies _____

Please list any medications you are currently taking _____

Reason for this dental visit _____

Date of last dental visit _____ What was done at that time? _____

Have you ever had braces? Y/N Have you ever had a root canal? Y/N Have you ever been treated for gum disease? Y/N

Are you happy with the appearance of your teeth? Y/N

Have you noticed any of the following? (Please circle)

Teeth tender to chew on?	Y/N	Recurring sore in or around the mouth	Y/N
Discomfort in face, head, neck, jaw	Y/N	Jaw clicking or popping	Y/N
Food caught between teeth	Y/N	Loose teeth	Y/N
Bleeding or sore gums	Y/N	Swelling, lumps in mouth	Y/N
Sensitivity to sweets, hot or cold	Y/N		

Have you had any problems with previous dental treatment? Y/N If yes, please explain _____

The information above is correct to the best of my knowledge.

Signature _____ Date ___/___/___

Medical Update: Initial _____ Date _____ Medical Update: Initial _____ Date _____

Medical Update: Initial _____ Date _____ Medical Update: Initial _____ Date _____