Dental Health History

Date:_____
Patient Name _____ Birthdate:_____

Dental History

Reason for today's visit? _____
Dentist? _____
Address _____
Date of last dental care?_____ Date of last dental x-rays?_____
How often do you floss? _____ How often do you brush? _____

Medical History

Physician's Name: _____ Date of last visit:_____
Any serious Illnesses or Operations? Yes No if Yes Describe:_____
Are you pregnant? Yes No **Nursing?** Yes No **Birth Control?** Yes No

Check (✓) if you have had problems with any of the following:

	AIDS		Cortisone treatments		High blood pressure		Scarlet Fever
	Anemia		Persistent cough		HIV positive		Shortness of breath
	Arthritis, Rheumatism		Cough up blood		Jaw pain		Skin Rash
	Artificial heart valves		Diabetes Type: ____		Kidney disease		Stroke
	Artificial joints		Epilepsy		Liver disease		Swelling of feet/ankles
	Asthma		Fainting		Mitral valve problems		Thyroid problems
	Back problems		Glaucoma		Nervous problems		Tobacco Habit
	Blood disease		Headaches		Pacemaker		Tonsillitis
	Cancer		Heart Murmur		Psychiatric care		Tuberculosis
	Chemical dependency		Heart problems		Radiation treatment		Ulcer(s)
	Chemotherapy		Hemophilia		Respiratory disease		Venereal disease
	Circulatory problems		Hepatitis		Rheumatic Fever		Other

MEDICATIONS		**ALLERGIES**
Current Medications:		Aspirin
		Barbiturates (sleeping pills)
		Codeine
		Local Anesthetic
		Penicillin
Pharmacy name:		Sulfa
Phone number:		Other:

The above information is accurate and complete to the best of my knowledge. I will not hold Dr. Christopher D. Elson or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature:_____
Date:_____