Health History

VALLEY DENTAL WORKS

Thank you for fill out this form completely. It will enable our office to be more effective in meeting your needs. If you have any questions at any time, please ask us. We will be happy to help.

Name: _____

Today's Date:___/___/___ Birthdate:___ /___/___ Home Phone Number: ( )

Email Address: _____

I'd like to receive email confirmations _____

Medical History

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name: _____

Address: _____
City State Zip

Phone #: (____) _____

Your current physical health is: ❑ Good ❑ Fair ❑Poor

Are you currently under the care of a physician? ❑ Yes ❑ No

Please explain: _____

_____

Do you smoke or use tobacco in any other form? ❑ Yes ❑ No

_____

Have you ever taken bisphosphonate medication such as Fosomax? ❑ Yes ❑ No

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Barbiturates
Y N Jewelry	Y N Sulfa Drugs	Y N Codeine
Y N Latex	Y N Dental Anesthetics	Y N Seasonal Hayfever
Y N Penicillin	Y N Other	

Please list additional drugs that cause allergic reactions:

_____

_____

For Women: Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Unsure ❑ Yes, week #: _____ ❑ No

Are you nursing? ❑ Yes ❑ No

Are you taking any prescription or over-the-counter drugs? ❑ Yes ❑ No

If yes, please list each one: _____

Have you experienced the following diseases or medical conditions?

Y N Abnormal Bleeding	Y N Emphysema	Y N Liver Disease
Y N Alcohol/Drug Abuse	Y N Epilepsy/Seizures	Y N Mitral Valve Prolapse
Y N Anemia	Y N Fainting Spells	Y N Osteoporosis
Y N Arthritis/Rheumatoid	Y N Frequent/Severe Headaches	Y N Pacemaker
Y N Artificial Bones/Joints	Y N Glaucoma	Y N Persistent Cough
Y N Artificial Heart Valves	Y N Heart Attack	Y N Psychiatric Problems
Y N Asthma	Y N Heart Murmur	Y N Radiation Treatment
Y N Blood Transfusion	Y N Heart Surgery	Y N Sinus Problems
Y N Cancer	Y N Hepatitis Type	Y N Steroid Therapy
Y N Chemotherapy	Y N Herpes/Fever Blisters	Y N Stroke
Y N Colitis/Ulcers	Y N High/Low Blood Pressure	Y N Thyroid Problems
Y N Congenital Heart Defect	Y N HIV+/AIDS	Y N Tuberculosis (TB)
Y N Diabetes	Y N Infective Endocarditis	Y N Venereal Disease
Y N Difficulty Breathing	Y N Kidney Problems	

Please list any hospitalizations or major surgeries in the last five years: _____

_____

List any serious medical condition(s) that you have experienced: _____

_____

I affirm that the information I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature of Patient, Parent or Guardian: _____ Date: _____