Patient Name: Compassionate Dentistry Health History

Sex M F Height_____ Weight_____ Single_____ Married_____

Do you have any current health problems?.....Yes No
Have you been hospitalized in the past 5 years?.....Yes No
Are you currently under the care of a physician?.....Yes No

Physician's Name:_____ Phone #_____

Address_____

Please explain any 'yes' answers from left:

For the following 30 questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit, you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

Do you have or have you had any of the following diseases or problems?

1. Damaged heart valves, including heart murmur, mitral valve prolapse or rheumatic heart disease?.....Yes No
2. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency coronary occlusion, high or low blood pressure, arteriosclerosis, stroke).....Yes No
   a. Do you have chest pains upon exertion?..... Yes No
   b. Are you ever short of breath after mild exercise or when lying down?.....Yes No
   c. Do your ankles swell?..... Yes No
   d. Do you have inborn heart defects?.....Yes No
   e. Do you have a cardiac pacemaker?..... Yes No
3. Allergy, Sinus trouble..... Yes No
4. Asthma..... Yes No
5. Osteoporosis/Osteopenia..... Yes No
6. Fainting spells or seizures..... Yes No
7. Persistent diarrhea or recent weight loss..... Yes No
8. Diabetes..... Yes No
9. Hepatitis, jaundice, or liver disease..... Yes No
10. AIDS or HIV infection..... Yes No
11. Thyroid problems..... Yes No
12. Respiratory problems, emphysema, bronchitis, etc..... Yes No
13. Arthritis or painful, swollen joints..... Yes No
14. Joint replacement surgery..... Yes No
15. Stomach ulcer or hyperacidity..... Yes No
16. Kidney Trouble..... Yes No
17. Tuberculosis..... Yes No
18. Persistent cough or cough that produces blood..... Yes No
19. Persistent swollen glands in neck..... Yes No
20. Sexually transmitted disease..... Yes No
21. Epilepsy or other neurological disease..... Yes No
22. Problems with mental health..... Yes No
23. Cancer..... Yes No
24. Treatment for a tumor or growth..... Yes No
25. Problems of immune system..... Yes No
26. Abnormal bleeding..... Yes No
27. Any blood disorder such as anemia..... Yes No
28. Drug dependency..... Yes No
29. Do you use tobacco..... Yes No
30. Women:
    a. Are you pregnant?..... Yes No
    b. Are you nursing?..... Yes No
    c. Are you taking birth control pills?..... Yes No

Are you allergic or have you had a reaction to any of the following medications or materials: Yes (circle which) No

Aspirin	Penicillin	Local Anesthetic
Codeine	Erythromycin	Novocaine
Vicodin	Tetracycline	Xylocaine
Sulfa drugs	Latex	Acrylic

Are you allergic to any other medications? Yes No
If so, what?_____

Please list all medications drugs and pills (including non-prescription) which you are now taking or have taken in the past two years:

Do you have any disease, condition, or problem not listed above that you think Dr. Davis should know about? Yes No
If so, please explain:_____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold Dr. Davis or any of his staff responsible for any errors or omissions that I may have made in the completion of this form. If I have any changes in my health status or if my medications change, I will inform Dr. Davis and his staff at the next appointment.

Patient Signature (Parent of child)_____ Date:_____

Reviewed by Dr. Davis:

Date:

Notes: