SOUTH COVE COMMUNITY HEALTH CENTER

DENTAL - MEDICAL HISTORY

Name:

DOB:

SCCHC ID#:

Date:

Health Questionnaire ***(Place a Check)*** ***Yes*** ***No***

1. ***Are you now, or have you recently been taking any drugs or Medicine?*** ___ ___
   If yes, please list:

2. ***Are you allergic or sensitive to any drugs, foods, latex or medicine*** ___ ___
   (e.g., Penicillin, aspirin, xylocaine, etc.)?

3. ***Do you have any difficulty with bleeding or healing from a cut wound, or tooth extraction?*** ___ ___
   Do you have frequent nose bleeds or bruise easily? ___ ___

4. ***Have you ever been hospitalized?*** ___ ___
   For what condition? ***How Long?*** ___ ___

5. ***Do you have or have you ever had any of the following (check where appropriate):***

	Yes	No		Yes	No
Rheumatic fever/heart disease	___	___	*Asthma or hay fever*	___	___
Heart murmur	___	___	*VD (syphilis or gonorrhea)*	___	___
Angina or chest pain	___	___	*Convulsion, epilepsy (seizures)*	___	___
Heart attack	___	___	*Nervous disorders*	___	___
Hypertension (high blood pressure)	___	___	*Diabetes (or family history)*	___	___
Stroke	___	___	*Fainting or dizziness*	___	___
Liver problems (hepatitis, jaundice)	___	___	*Inflammatory arthritis*	___	___
Kidney problems (infections, etc.)	___	___	*Tumors or growths*	___	___
Sinus problems	___	___	*Skin disease or problems*	___	___
Lung problems (TB, pneumonia, asthma)	___	___	*Thyroid problems*	___	___
Anemia (thin blood) or any blood diseases	___	___	*Osteoporosis*	___	___
Stomach or intestinal problems (Ulcers)	___	___	*High cholesterol*	___	___
Other _____				___	___

6. ***Are you now or have you recently been under the care of a physician?*** ___ ___
   Name of M.D. _____ ***Address*** _____

7. ***When did you have your last physical examination?*** _____

8. ***Have you experienced a recent rapid loss or gain in weight or appetite?*** ___ ___

9. ***<u>Women</u> : Are you pregnant now?*** ***Yes*** ___ ***No*** ___ ***No of months*** _____
   Are you taking birth control pills? ***Yes*** ___ ***No*** ___

10. ***<u>Child Patients</u> : when was your child's last physical examination or Immunization?*** _____
    Does your child suck his/her thumb or fingers? ***Yes*** ___ ***No*** ___
    Does your child have a speech problem? ***Yes*** ___ ***No*** ___

I certify that this health history is correct and I consent for the patient named above to receive all necessary treatment. I understand the propased treatment will be explained to me by the dental personnel.

Your signiture (patient, parent, or guardian) _____ ***Date:*** _____

_____ ***Date:*** _____

_____ ***Date:*** _____