

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. Women : Are you pregnant now? Yes ___ No ___ No of months _____
Are you taking birth control pills? Yes ___ No ___

10. Child Patients : 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 proposed treatment will be explained to me by the dental personnel.

Your signature (patient, parent, or guardian) _____ Date: _____

_____ Date: _____

_____ Date: _____