Friendly Smiles
Family Dentistry

Patient Name _____ Date _____

HEALTH HISTORY QUESTIONNAIRE

Honest answers to the questions stated below are important to the provision of dental care. If you are uncertain about the question or how it relates to your health, please discuss it with a member of our staff. You can be assured that the information you provide will not be released without your express permission.

MEDICAL HISTORY

***Circle** if you have, or have had, any of the following:*

ADD/ADHD	Birth Control	Heart Disease	Problem Reclining
Addiction, history of	Blood Thinners	Hepatitis/Liver Problems	See Notes below - Other
AIDS/ARC/HIV	Cancer	High or Low Blood Pressure	Seizures/Epilepsy
Allergies - Sinus	Celiac Disease	History of Smoking/Tobacco	Shingles
Allergy- Red Dye	Chemo/Radiation	Lyme Disease	Skin Reaction to Jewelry
Allergy - Penicillin	Dental Anxiety	Migraines	Sleep Apnea
Allergy - Tetracycline	Depression/Anxiety	Multiple Sclerosis	Smoking/Tobacco
Allergy – Other	Diabetes/Hypoglycemia	Nausea from Fluoride	Stomach Problems/Ulcers
Anemia - Bleeding	Dialysis/Kidney Problems	No Epinephrine	Thyroid Disease
Anesthesia Problem	Dry Mouth	Non-Fluoridated/Well Water	TMJ/TMD
Anesthesia Refusal	Emphysema/COPD	Oral Piercing	Tuberculosis
Angina/Chest Pain	Gag Reflex	Osteoporosis	Vision Impairment
Arthritis	Handicaps/Disabilities	Pacemaker	Weight Loss Surgery
Artificial Joints	Hearing Loss	Panic Attacks	
Asthma	Heart Attack/Stroke	Parkinson's Disease	*Women: Nursing*
Back Problems	Heart Catheter/Stent	Premedication	*Pregnant/Anticipating Pregnancy*

Do you have any health problems or allergies not covered in this form? Please describe.

_____

_____

Please list all of your medications. Include all prescriptions and over the counter medications (herbal medicines, pain relievers, vitamins). **Please note by each medication the reason you take it.**

_____

_____

I have answered all questions truthfully and to the best of my recollection. If there should be a change in my health, I am to inform Dr. Verdinelli at the earliest convenience.

_____ Patient or Guardian

Signature Date

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