

HEALTH HISTORY

ROBERT E. GILLIS JR., D.M.D., M.S.D.

PATIENT'S NAME _____ **DATE** _____

GENERAL DENTIST'S NAME & ADDRESS	PHYSICIAN'S NAME & ADDRESS

PLEASE ANSWER ALL QUESTIONS

1. Has there been any change in your health during the past year? <input type="checkbox"/> YES <input type="checkbox"/> NO	11. Do you experience popping or clicking in your jaw when opening or closing? <input type="checkbox"/> YES <input type="checkbox"/> NO
2. Have you been under the care of a physician within the past 5 years? if yes, please explain. _____ _____	12. Are you aware that you grind or clench your teeth? <input type="checkbox"/> YES <input type="checkbox"/> NO
3. Have you been hospitalized within the last 5 years? if yes, please explain. _____ _____	13. Do you use tobacco? In what form and for how long? <input type="checkbox"/> YES <input type="checkbox"/> NO
4. Have you ever had excessive bleeding requiring special treatment? <input type="checkbox"/> YES <input type="checkbox"/> NO	14. Are you nervous or uneasy about dental treatment? <input type="checkbox"/> YES <input type="checkbox"/> NO
5. Have you ever had a blood transfusion? If yes, what year? <input type="checkbox"/> YES <input type="checkbox"/> NO	15. Have you ever had a bad experience in a dental office? <input type="checkbox"/> YES <input type="checkbox"/> NO
6. Have you experienced recurrent illness, unintentional weight loss, oral soft tissue, ulcers, night sweats, or enlarged glands? <input type="checkbox"/> YES <input type="checkbox"/> NO	16. Do you gag easily? <input type="checkbox"/> YES <input type="checkbox"/> NO
7. Have you had surgery or x-ray treatment for a tumor, growth or other condition? If yes, please explain. _____ _____	17. Do you faint easily? <input type="checkbox"/> YES <input type="checkbox"/> NO
8. Do you have any surgical implants? (ie; Knee, Hip, or Heart Valve)? <input type="checkbox"/> YES <input type="checkbox"/> NO	18. Have you ever used NITROUS OXIDE (laughing gas) during your dental treatment? Would you like to? <input type="checkbox"/> YES <input type="checkbox"/> NO
9. Do you have head, neck, or dental pain or discomfort at this time? <input type="checkbox"/> YES <input type="checkbox"/> NO	19. Have you ever used "Phen-Phen"? <input type="checkbox"/> YES <input type="checkbox"/> NO
10. Do you have jaw pain or discomfort when chewing or swallowing? <input type="checkbox"/> YES <input type="checkbox"/> NO	20. Women: are you taking birth control pills? <input type="checkbox"/> YES <input type="checkbox"/> NO
	21. Women: are you pregnant? If yes, how many months? _____ <input type="checkbox"/> YES <input type="checkbox"/> NO
	22. Are you allergic to penicillin, codeine, or any other medication? If other, please list? _____ <input type="checkbox"/> YES <input type="checkbox"/> NO
	23. Have you ever had any reaction to metallic substance or costume jewelry? (Example: rash, itching, allergy?) <input type="checkbox"/> YES <input type="checkbox"/> NO
	24. Are you pleased with your smile and/or the appearance of your teeth? If no, please explain: _____ _____ _____ <input type="checkbox"/> YES <input type="checkbox"/> NO

PLEASE TURN OVER AND COMPLETE REVERSE SIDE

PLEASE COMPLETE THE FOLLOWING AND SIGN WHERE NECESSARY

22. Circle any of the following which you have had or have at the present

- | | | |
|--------------------------|---------------------|--------------------|
| AIDS | HEART MURMUR | PERSISTANT COUGH |
| AIDS RELATED COMPLEX | HEART TROUBLE | RHEUMATIC FEVER |
| ANEMIA | HEMOPHILIA | SJOGREN'S SYNDROME |
| ARTHRITIS | HEPATITS | SINUS TROUBLE |
| ASTHMA | HERPES | STROKE |
| COLD SORES | HIGH BLOOD PRESSURE | TUBERCULOSIS |
| CONGENITAL HEART LESIONS | HIV | HIVES OR SKIN RASH |
| TUMOR OR GROWTH | DIABETES | JAUNDICE |
| ULCERS | EPILEPSY | KIDNEY DIALYSIS |
| VENERAL DISEASE | GLAUCOMA | |

ARE YOU TAKING COUMADIN OR BLOOD THINNER?

23. Do you have any disease condition or problem not listed above that you think we should be aware of?

YES	NO

If yes, please explain _____

24. Please list any medication you are currently taking, or have taken in the last year. List dosage, how often you take it, and for what condition.

YEAR/MONTH	MEDICATION	DOSAGE	REASON

To the best of my knowledge, all of the preceding answers are true and correct. If I have any change in my health or if my medications change, I will inform the doctor at my next appointment.

Today's Date _____ Patient's Signature _____ Parent/Guardian Signature _____

OFFICE USE ONLY

HEALTH HISTORY REVIEW AND UPDATE

DATE: _____ ASSISTANT'S INITIALS _____ DOCTOR'S INITIALS _____ BLOOD PRESURE _____ DATE: _____

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