

DENTAL INFORMATION

Date of Last Dental Treatment _____ Date of Last Dental Xrays _____

Last Dental Office _____
Name Phone

Have you ever had any unfavorable reaction from a local anesthetic? Yes / No If so, please explain _____

Have you had any serious trouble associated with any previous dental treatment? Yes / No If so, please explain _____

MEDICAL HISTORY

Your answers are for our records only and will be considered confidential.

Sex _____ Height _____ Weight _____

In the following questions circle yes or no, whichever applies.

1. Yes / No Are you in good health?
2. Yes / No Has there been any change in your general health within the past year? Date of last physical exam _____
3. Yes / No Are you now or have you been under the care of a physician during the past two years?
If so, what is the condition being treated? _____
Physician's name _____ Phone _____
4. Yes / No Have you ever been hospitalized or had a serious illness? If so, what was the problem?

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR CONDITIONS?

CARDIOVASCULAR

Yes / No	Rheumatic Fever
Yes / No	Congenital Heart Defect – type: _____ Surgery date: _____
Yes / No	Angina Pectoris – frequency: _____
Yes / No	Myocardial Infarction (Heart Attack) _____ Date: _____
Yes / No	Arrhythmias (Irregular heart beat) –type: _____
Yes / No	Cardiac Murmur (cause): _____
Yes / No	Congestive Heart Failure _____ Date: _____
Yes / No	Heart Surgery – type: _____ Date: _____
Yes / No	Pacemaker Implanted – type: _____ Date: _____
Yes / No	Hypertension (High Blood Pressure) – BP _____ / _____
Yes / No	Hypotension (Low Blood Pressure) - BP _____ / _____
Yes / No	Stroke (CVA) _____ Date: _____
Yes / No	Other (explain) _____

RESPIRATORY DISEASE

Yes / No	Asthma – severity: _____
Yes / No	Emphysema – severity: _____
Yes / No	Bronchitis – severity: _____
Yes / No	Hay Fever or Sinusitis
Yes / No	Other (explain) _____

ORTHOPEDIC SURGERIES

Yes / No	Hip Replacement	Date: _____	Yes / No	Shoulder Replacement	Date: _____
Yes / No	Knee Replacement	Date: _____	Yes / No	Other Joint Replacement	Date: _____

ENDOCRINE DISORDERS

Yes / No	Diabetes – type: _____ Control: _____
Yes / No	Hyperthyroidism (High Thyroid)--- Treatment: _____
Yes / No	Hypothyroidism (Low Thyroid)--- Treatment: _____

HEMATOLOGIC (BLOOD) DISORDERS

Yes / No	Anemia – type: _____
Yes / No	Leukemia- type: _____
Yes / No	AIDS or HIV Positive
Yes / No	Bleeding Tendency—Do you bruise easily or bleed excessively when cut? If yes – explain: _____
Yes / No	Have you ever had a blood transfusion? If yes, explain : _____

PSYCHIATRIC CONDITIONS				
Yes / No	Have you seen a psychiatrist in the last 3 years? Psychiatrist: _____			Phone #: _____
INFECTIOUS DISEASES				
Yes / No	Hepatitis – type: _____	Date: _____	Yes / No	MRSA _____ Date: _____
Yes / No	Venereal Disease –type: _____	Date: _____	Yes / No	VRE _____ Date: _____
Yes / No	Tuberculosis _____	Date: _____	Yes / No	Other _____ Date: _____
RENAL (KIDNEY) DISEASE				
Yes / No	Have you had a kidney infection within the last 3 years? Type: _____			Date: _____
Yes / No	Have you had kidney surgery? Type: _____		Date: _____	
OTHER DISEASES & DISORDERS				
Yes / No	Syncope (fainting) frequency: _____			
Yes / No	Liver Disease – type: _____			
Yes / No	Arthritis – type: _____			
Yes / No	Ulcers – type: _____			
Yes / No	Glaucoma _____			
Yes / No	Radiation Therapy – type _____		Date: _____	
Yes / No	Epilepsy – treatment: _____			
Yes / No	Cancer – type _____		Date: _____	
Yes / No	Have you had surgery or xray treatment for a tumor, growth or other condition? _____			
MEDICATION - ARE YOU TAKING ANY OF THE FOLLOWING?				
Yes / No	Antibiotics or sulfa drugs- type: _____		Amount: _____	
Yes / No	Anticoagulants (Blood Thinners) _____		Amount: _____	
Yes / No	Steroids (Cortisone) – type: _____		Amount: _____	
Yes / No	High Blood Pressure Medication - type _____		Amount: _____	
Yes / No	Tranquilizers – type _____		Amount: _____	
Yes / No	Aspirin- how often? _____		Amount: _____	
Yes / No	Insulin, tolbutamide (Orinase) or similar drug – type: _____		Amount: _____	
Yes / No	Digitalis or drugs for heart trouble - type: _____		Amount: _____	
Yes / No	Nitroglycerin _____		Amount: _____	
Yes / No	Oral contraceptive or other hormonal therapy – type _____		Amount: _____	
Yes / No	Other Drugs: _____	Frequency: _____	Amount: _____	
Yes / No	Other Drugs _____	Frequency: _____	Amount: _____	
Yes / No	Other Drugs _____	Frequency: _____	Amount: _____	
ALLERGIES				
Yes / No	Do you have allergies to latex? _____			
Yes / No	Do you have allergies to any medications or foods? If so please list: _____			
WOMEN ONLY				
Yes / No	Are you pregnant? _____		Due date: _____	
Yes / No	Are you nursing? _____			
GENERAL QUESTIONS				
Yes / No	Have you ever taken the diet pill Phen-Fen _____			
Yes / No	Do you use tobacco products? If so which? Cigarettes / Cigar / Pipe / Chewing Tobacco / other _____			
Yes / No	Do you consume alcohol? If so how much? Light / Moderate / Heavy _____			
Yes / No	Do you wear contact lenses? _____			
Yes / No	Are you employed in any situation which exposes you regularly to xrays or other ionizing radiation? _____			
Yes / No	Do you have any problem or condition not listed above? Please explain: _____			

CONSENT: The undersigned hereby authorizes Doctor to take Xrays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the patient whose name appears on this Health History form and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies certain risk. I understand that responsibility for payment for dental services provided in this office for me or my dependents are due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1>5% finance charge (18% annually) will be added to any patient balance over 60 days. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient or Responsible Party _____ Date _____

Relationship to Patient _____

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