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ST. PETERSBURG DENTAL CENTER

Introduction & Adult Health History Sheet

IN ORDER THAT WE MAY THOROUGHLY EVALUATE YOUR DENTAL PROBLEM, YOUR KINDNESS IN FURNISHING THE FOLLOWING INFORMATION WILL BE APPRECIATED. ALL ANSWERS WILL BE HELD IN STRICT CONFIDENCE AND USED IN THE PREPARATION OF YOUR CLINICAL TREATMENT CHART.

1. PATIENT'S NAME	2. BIRTHDATE:	ADDRESS	CITY	STATE ZIP
LAST F RST M.	MO. DAY YEAR (Jan 1 2010)			WY

SS # EMAIL

EMPLOYED BY:

HOME PHONE:
CELL PHONE:
WORK PHONE (PT):
REFERRED BY:

SPOUSE NAME EMPLOYED BY SPOUSE WORK PHONE

PHYSICIANS NAME ADDRESS PHONE

Are you receiving treatment from a physician at the present time? YES NO
If so, for what?

Has a physician ever told you that you have heart trouble? YES NO

Have you ever been treated for high or low blood pressure? YES NO

Do you ever have severe heart or chest pains? YES NO

Have you ever had a stroke or heart attack? YES NO

Have you ever had rheumatic fever? YES NO

Do you have a prosthetic (artifical) heart valve, heart murmur or Mitral Valve Prolapse? YES NO

Do you hae a heart pacemaker YES NO

Have you ever had severe & prolonged bleeding after cuts or tooth extractions? YES NO

Do you take insulin or receive other treatment for diabetes? ("Sugar Disease") YES NO

Have you ever been treated with CORTISONE or ACTH within the past year? YES NO

Are you HIV Positive? YES NO

Do you ever have seizures or convulsions? YES NO

Have you ever had Hepatitis? YES NO

Are you allergic (sensitive) to any food or drugs? YES NO
If so, for what?

Are you taking any medicines at the present time? YES NO
If so, for what?

Do you have any prosthetic (artificial) joints? (knee, hip, etc.) YES NO

Have you ever had any popping, clicking or pain in your Temporamandibular Joint (TMJ)? YES NO

Have you ever had an allergic reaction to latex products? YES NO

Have you ever had surgery on X-ray treatment for a tumor, growth or other condition in your mouth or on your lips, or other areas of the body? YES NO

Have you ever been given general anesthetic (been put to sleep), either for oral surgery or any other type of surgery? YES NO

WOMEN: Are you pregnant at the present time? YES NO
Are you taking Birth Control Pills? YES NO

Have you ever had severe & prolonged bleeding after cuts or tooth extractions? YES NO

Have you any OTHER reason to think that you are not now in good health? YES NO
If so, what?

UPDATES:

Date Initials Date Initials Date Initials

Patient's Signature Date