Confidential Medical History

St. Johnsbury Dental Associates, Inc.

Date: _____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Name_____Date of birth_____Social Security #_____

Marital Status: married_____ single_____ divorced_____ spouse name_____

Mailing Address_____Town_____State_____ZIP_____

Home Phone_____Cell Phone_____Work Phone_____Employer_____

Person responsible for this account:_____

Do you have dental insurance?_____

Reason for this dental visit_____

Date of last dental cleaning_____

Previous dentist_____Physician_____

The following information is requested to enable us to give you the most consideration for your time and well being. This information, important for our records and your health, is confidential. Items 1-14 below will not be entered into our computer. Please fill in the following information completely.

Please indicate as appropriate:	NO	YES	Comments
1. Are you having pain or discomfort at this time?	[ ]	[ ]	
2. Do you feel nervous about dental treatment?	[ ]	[ ]	
3. Have you had an unpleasant experience in a dental office?	[ ]	[ ]	
4. Are you under the care of a medical doctor now?	[ ]	[ ]	
5. Are you taking any medications now?	[ ]	[ ]	List:
6. Are you allergic to penicillin or other drugs?	[ ]	[ ]	
7. Do you require a premedication of any kind before dental treatment?	[ ]	[ ]	

Please answer yes or no to the following:

NO	YES		NO	YES		NO	YES		NO	YES	
[ ]	[ ]	Angina	[ ]	[ ]	Emphysema	[ ]	[ ]	AIDS	[ ]	[ ]	Diabetes
[ ]	[ ]	Heart Attack/Disease	[ ]	[ ]	Tuberculosis	[ ]	[ ]	Anemia	[ ]	[ ]	Pain in Jaw Joints
[ ]	[ ]	Heart Failure	[ ]	[ ]	Chronic Cough	[ ]	[ ]	Sickle Cell Anemia	[ ]	[ ]	Gum (Perio) Surgery
[ ]	[ ]	Heart Surgery	[ ]	[ ]	Asthma	[ ]	[ ]	Hemophilia	[ ]	[ ]	Bleeding Gums
[ ]	[ ]	Artificial heart valve(s)	[ ]	[ ]	Cold Sores	[ ]	[ ]	Blood Transfusion(s)	[ ]	[ ]	Sinus Problems
[ ]	[ ]	Heart pacemaker	[ ]	[ ]	Drug Addiction	[ ]	[ ]	Bruise/Bleed Easily	[ ]	[ ]	Psychiatric Treatment
[ ]	[ ]	Heart Murmur	[ ]	[ ]	Alcohol Addiction	[ ]	[ ]	Cancer/Tumor	[ ]	[ ]	Depression/Anxiety
[ ]	[ ]	Rheumatic or Scarlet Fever	[ ]	[ ]	Smoke/Chew Tobacco	[ ]	[ ]	Chemo Therapy	[ ]	[ ]	Fainting/Dizzy Spells
[ ]	[ ]	High Blood Pressure	[ ]	[ ]	Hepatitis A	[ ]	[ ]	Radiation Therapy	[ ]	[ ]	Epilepsy/Seizure Disorder
[ ]	[ ]	Stroke	[ ]	[ ]	Hepatitis B	[ ]	[ ]	Allergies/Hives	[ ]	[ ]	Artificial Joints
[ ]	[ ]	Congenital heart lesions	[ ]	[ ]	Hepatitis C	[ ]	[ ]	Hay Fever	[ ]	[ ]	Arthritis
[ ]	[ ]	Thyroid Disease	[ ]	[ ]	Venereal Disease	[ ]	[ ]	Migraine Headaches	[ ]	[ ]	Allergy to Latex
[ ]	[ ]	Kidney Problems	[ ]	[ ]	Tested for AIDS	[ ]	[ ]	Cortisone Medicine			
[ ]	[ ]	Ulcers	[ ]	[ ]	HIV+	[ ]	[ ]	Glaucoma			

	NO	YES
8. Do you have any disease or condition not listed above?	[ ]	[ ]
9. Do you have any problems that you would like to discuss with me personally?	[ ]	[ ]
10. When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired?	[ ]	[ ]
11. Do your ankles swell during the day?	[ ]	[ ]
12. Do you use more than two pillows to sleep?	[ ]	[ ]
13. Have you lost or gained more than 10 pounds in the last year?	[ ]	[ ]

14. Women: Are you pregnant?_____ Due Date:_____

Authorization is granted for necessary dental service.

To the best of my knowledge, all of the preceeding answers are true and correct. I understand that my personal physician may be contacted if there are questions or concerns about my medical history. If I ever have any change in my health, or if my medicines change, I will inform the dentist at the next appointment without fail. Use other side if necessary.

_____

Signature of Patient, Parent or Guardian