

Health Questions

Robert M. Dutton, DDS

Today's date _____

Name (last, first) _____ **Date of birth** _____ **Sex M F** **SSN** _____

Phone numbers-Home _____ **Work** _____ **Cell** _____

Marital status _____ **Occupation** _____ **Email** _____

Address (complete) _____

Physician's name and address _____

Do you have or have you had any of the following illnesses or diseases?

Y or N **Congenital heart disease**

Y or N **Heart disease e.g. high blood pressure, infarct, artificial heart valve**

Y or N **Central nervous disorder, including stroke**

Y or N **Neurologic illness e.g. epilepsy, seizures, etc.**

Y or N **Psychiatric disorder e.g. depression, bipolar disorder, etc.**

Y or N **Lung disease e.g. tuberculosis, pneumonia**

Y or N **Asthma, hay fever, sinusitis**

Y or N **Osteoporosis or osteopenia**

Y or N **Diabetes**

Y or N **Stomach and bowel disease including ulcers, etc.**

Y or N **Liver disease e.g. hepatitis or jaundice**

Y or N **Blood disease e.g. anemia, leukemia, thrombocytopenia, abnormal blood count**

Y or N **Infectious disease including venereal**

Y or N **Arthritis**

Y or N **Hip, knee or other joint replacement --if yes when did you receive it**

Y or N **Cancer**

Y or N **Other diseases or illnesses not listed above**

Circle any of the following drugs or medications you are taking:

**antibiotics / anticoagulants / blood pressure medication / chemotherapy drugs / digitalis / steroids / tranquilizers /
diabetic medications / sedatives / osteoporosis medication / antihistamines / anti-depressants / diet pills / other drugs**

Circle any of the following that you are allergic to:

**penicillin / sulfas / tetracycline / clindamycin / iodine / local anesthesia / latex / sedatives / aspirin / codeine /
any allergies not listed above?**