Brazos Valley Periodontics Center

Practice Limited to Periodontal Therapy and Dental Implant Surgery

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HEALTH HISTORY

1. Are you having pain or discomfort at this time? _____ YES NO
2. Do you feel nervous about having dental treatment? _____ YES NO
3. Have you ever had a bad experience in the dental office? _____ YES NO
4. Have you been hospitalized during the past two years? _____ YES NO
5. Have you been under the care of a physician during the past two years? _____ YES NO
   Physician's Name _____
   Address _____ Phone # _____
6. Are you now taking any medication, drugs or pills? _____ YES NO
   If yes, please list: _____
7. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? _____ YES NO
   If yes, please list: _____
8. If you smoke, please list how many packs _____ per day, and for _____ years.
9. Do you use other tobacco products? (Snuff, chewing tobacco, etc.) _____ YES NO
10. Indicate which of the following you have had or have at the present:

Heart Failure	YES	NO	Emphysema	YES	NO
Heart Disease/Attack	YES	NO	Cough	YES	NO
Angina Pectoris	YES	NO	Tuberculosis	YES	NO
Heart Murmur	YES	NO	Asthma	YES	NO
Rheumatic Fever	YES	NO	Hay Fever/Allergies	YES	NO
Scarlet Fever	YES	NO	Artificial Heart Valve	YES	NO
Thyroid Disease	YES	NO	Heart Pacemaker	YES	NO
Artificial Joints (Hip, Knee)	YES	NO	Diabetes	YES	NO
Anemia	YES	NO	Chemotherapy	YES	NO
Stroke	YES	NO	Arthritis	YES	NO
Kidney Trouble	YES	NO	Cortisone Medication	YES	NO
Ulcers	YES	NO	Glaucoma	YES	NO
Cosmetic Surgery(any type)	YES	NO	Pain in jaw joints	YES	NO
High Blood Pressure	YES	NO	Hepatitis A or B	YES	NO
Liver Disease	YES	NO	Drug Addiction	YES	NO
Blood Transfusion	YES	NO	Sexually Transmitted Diseases	YES	NO
Hemophilia	YES	NO			
Fever Blisters	YES	NO	Epilepsy/Seizures	YES	NO
Fainting/Dizzy Spells	YES	NO	Leukemia	YES	NO
AIDS/HIV	YES	NO	Bruise Easily	YES	NO

11. Do you tire easily, have pain in your chest, or shortness of breath when climbing stairs or walking short distances? _____ YES NO
12. Do your ankles swell during the day? _____ YES NO
13. Do you use more than 2 pillows to sleep? _____ YES NO
14. Have you lost or gained more than 10 pounds in the past year? _____ YES NO
15. Do you wake up from sleep short of breath? _____ YES NO
16. Are you on a special diet? _____ YES NO
17. Has your physician ever diagnosed you with cancer or a tumor? _____ YES NO
18. Do you have any condition not listed? _____ YES NO
19. Do you have any Immuno suppressive diseases? _____ YES NO

FOR WOMEN ONLY:

Are you pregnant? YES NO If yes, what month are you in? _____
Are you taking birth control pills: YES NO

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature _____ Date _____