HEALTH HISTORY

Patient's Name _____ Date of Birth: _____

Answers to the following questions are for our records only and will be considered confidential.

1. Have you or any member of your family been treated by Dr. Truitt's office? _____
2. Date of Last Physical Examination_____Physician's Name _____
3. Date of Last Dental Examination_____Dentist's Name _____
4. Date of Last Dental X-Rays_____

CIRCLE

YES NO 5. Are you having pain or discomfort at this time?_____
YES NO 6. Have you been a patient in the hospital during the past two years?_____
YES NO 7. Have you been under the care of a medical doctor during the past two years?_____
YES NO 8. Have you taken any medicines or drugs in the last two years? If so, which ones?_____
YES NO 9. Are you taking any vitamins, herbal supplements or "cures"?_____
YES NO 10. Are you allergic to (i.e.,itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, any drugs, medications, or metals?_____
YES NO 11. Have you ever had any excessive bleeding requiring special treatment?_____

12. Circle any of the following which you have had or have at present:

Heart Failure	Ulcers	Alcoholism	Herpes
Heart Disease or Attack	Mental Retardation	Cortisone Medicine	Epilepsy or Seizures
Angina Pectoris	Emphysema	Glaucoma	Fainting or Dizzy Spells
High Blood Pressure	Cold Sores	Pain in Jaw Joints	*Any Type of implant
*Heart Murmur	Tuberculosis (TB)	Birth Defects	(Heart Valve, etc.)
*Rheumatic Fever	Asthma	HIV Positive, ARC, AIDS	Psychiatric Treatment
*Congenital Heart Lesions	Hay Fever	Hepatitis A (infectious)	Sickle Cell Disease
Arthritis	Sinus Trouble	Hepatitis B (serum)	Bruise Easily
Thyroid Disease	Allergies or Hives	Liver Disease	*Artificial Hip, knee or
Heart Pacemaker	Diabetes	Jaundice	Other Joint
Heart Surgery	Sexually Transmitted Diseases	Blood Transfusion	
Cancer (Type:_____)	Radiation Therapy	Drug Addiction	
Anemia	Chemotherapy	Hemophilia	
Stroke	(Cancer, Leukemia)	*Any type of Transplant	
Kidney Trouble			

*Antibiotic premedication may be required prior to your appointment.

CIRCLE

YES NO 13. Do you smoke?
YES NO 14. Do you chew tobacco?
YES NO 15. Do you use snuff?
YES NO 16. Have you ever taken prescription Redux or Pondimin (Fen Phen)?
YES NO 17. Have you ever had any instructions in oral hygiene?
YES NO 18. Are there now any growths or sores in or around your mouth?
YES NO 19. Do you have any trouble chewing?
YES NO 20. Does food catch between your teeth?
YES NO 21. Do you have pain in or near your ears?
YES NO 22. Do you habitually clench or grind your teeth during the day or night?
YES NO 23. Have you ever been told that you have gum problems?
YES NO 24. Do you now have bleeding gums or any other gum condition?
YES NO 25. WOMEN: Are you pregnant now?
YES NO 26. Is there anything related to your medical or dental history that you have not indicated above? If yes, explain:

_____

27. Purpose of this dental visit?_____

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. If I am delinquent in paying my account, I agree to pay interest on the overdue balance at a rate of 1 ½ % per month. I acknowledge that I am responsible for informing the doctor about any changes in my health history prior to treatment. I understand that my health history information will be used as necessary for diagnosis or treatment. I understand that antibiotics may reduce the effectiveness of birth control pills.

SIGNATURE: _____ DATE:_____

DMD SIGNATURE: _____ DATE:_____