

# HEALTH HISTORY

Today's Date: \_\_\_\_\_

Thank you for taking the time to fill out this form completely. This information will enable us to provide you with a thorough evaluation and quality treatment. Your complete comfort and satisfaction are our primary concern.

Name: \_\_\_\_\_ Phone # \_\_\_\_\_ DOB: \_\_\_\_\_ Dentist: \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone: \_\_\_\_\_ Alt. Phone \_\_\_\_\_

Are you under the care of a physician for any illness or health problem (for the last two years)? <b>YES NO</b>	
Date of last exam _____	Medical record # _____
Physicians: 1. _____	Phone _____ Specialty _____
2. _____	Phone _____ Specialty _____

**Do you have or have you had any of the following health conditions? PLEASE provide information for all YES answers**

Are you required to take any antibiotics prior to dental treatment?	YES NO
Rheumatic Fever/Scarlet Fever/Rheumatic or Congenital Heart Disease/Heart Murmur/Mitral Valve Prolapse	YES NO
Heart Trouble/Heart Attack/Angina/Heart Pacemaker	YES NO
Artificial Limb, Joint or Heart Valve	YES NO
Stroke	YES NO
High/Low Blood Pressure	YES NO
Fainting Spells, Seizures/Epilepsy	YES NO
Diabetes (any family history?)	YES NO
Restricted Diet of Any Kind	YES NO
Cancer/Tumors	YES NO
Kidney Trouble	YES NO
Respiratory Lung Disorders/Tuberculosis/Asthma/Emphysema/Etc.	YES NO
Stomach or Intestinal Problems	YES NO
Excessive Bleeding, Bruising or Anemia	YES NO
Hepatitis, Jaundice, Liver Disease	YES NO
Cold Sores/Herpes	YES NO
HIV, ARC, AIDS	YES NO
Syphilis/Gonorrhea	YES NO
Arthritis	YES NO
Glaucoma	YES NO
Psychiatric Care	YES NO
Do you have a history of drug or alcohol abuse?	YES NO
If you are a woman, are you pregnant or planning pregnancy?	YES NO
Does your health restrict your physical activity in any way?	YES NO
Are you taking <b>ANY</b> medications (prescriptions and/or over-the-counter, including <b>Fosamax</b> , aspirin, vitamins, Meridia, hormones, birth control pills, diet pills including fen-phen, etc.)?	YES NO
Do you have any allergies or adverse side effects to any drugs or medications, such as Novocaine, Xylocaine, Aspirin, Penicillin, Codeine, Fluoride, Mouthwash, etc.? (please list) Are you allergic to latex?	YES NO
Do you have any disease, condition or handicap not listed above? (please list)	YES NO

List Major Surgeries/Hospitalizations: \_\_\_\_\_

**I CERTIFY THAT THE INFORMATION ON THIS FORM IS COMPLETE AND ACCURATE.**

Patient/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

Reviewed by Doctor \_\_\_\_\_ Date \_\_\_\_\_

**HEALTH UPDATE -- DOCTOR USE ONLY**

Date Reviewed \_\_\_\_\_ By Dr. \_\_\_\_\_ Changes \_\_\_\_\_

## DENTAL HISTORY

How long have you been seeing your general dentist?

How can we help you? What is your chief concern?

Are you experiencing any discomfort or pain at this time?	YES	NO
Are you satisfied with the appearance of your teeth?	YES	NO
Are you able to eat and chew foods satisfactorily?	YES	NO
Are you aware of clenching or grinding your teeth?	YES	NO
Do you have frequent headaches, earaches or neck pain?	YES	NO
Do you frequently experience sinus problems?	YES	NO
Have you had ANY serious trouble associated with ANY previous dental treatment?	YES	NO
Have you ever had any periodontal treatment, such as deep cleaning/root planing or surgery? If so, when?	YES	NO

Again, thank you for your time.

Judson R. Roberts, DDS  
Robin H. Berrin, DDS  
Judith V. Lane, DDS  
Robert W. Pretel, DDS, MSD

*Capitol*  
**PERIODONTAL**  
G R O U P  
*Periodontics & Implant Dentistry*

P. Paul Towfighi, DDS, MS  
P. Kevin Chen, DMD, MS  
Rosemary Wu, DMD, MS

**Sacramento Office**  
1810 Professional Drive  
Sacramento, California 95825  
(916) 971-3461  
(916) 973-9830 Fax

**Laguna Office**  
9309 Office Park Circle, Suite 110  
Elk Grove, California 95758  
(916) 684-3379  
(916) 684-4106 Fax

**Roseville Office**  
2428 Professional Drive, Suite 100  
Roseville, California 95661  
(916) 786-6585  
(916) 786-7542 Fax

**Folsom Office**  
2535 East Bidwell, Suite 150  
Folsom, California 95630  
(916) 984-1109  
(916) 984-1764 Fax