Health History (Office of Dwaine E. Valentine, D.D.S., Inc.)

Name_____ _____ _____D.O.B._____
First Last MI

Address_____City_____State_____Zip_____

Home Phone_____Cell_____Business_____

Date of Last Dental Visit _____Referred By_____SS#_____

Dental History – Check and Circle the Condition if You Have Had Any of the Following:

- ☐ Bad Breath or Food Collection Between Teeth
- ☐ Bleeding Gums, Gingivitis or Previous Periodontal Treatment
- ☐ Clenching/Grinding, Popping Jaw, Earaches, Neck Pains
- ☐ Broken Tooth/Teeth , Loose Fillings, Loose Teeth, Current Discomfort
- ☐ Sensitive to Hot, Cold, Sweets or to Biting
- ☐ Growth or Sore in Mouth

How Often Do You Brush?_____ How Often Do You Floss?_____

Do You Use Tobacco (smoking, snuff, chew, bidis)? Yes_____ No_____

Medical History – Check and Circle the Condition if You Have Had Any of the Following:

- ☐ Angina or Chest Pain on Exertion/ Heart Attack
- ☐ Artificial Heart Valve or Damaged Heart Valves
- ☐ Artificial Joints Date of Placement_____
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Blood Disease
- ☐ Blood Transfusion Date of Transfusion_____
- ☐ Cancer/Chemotherapy/Radiation Treatment
- ☐ Cardiovascular Disease or Circulatory Problems
- ☐ Chemical Dependency
- ☐ Congestive Heart Failure
- ☐ Diabetes Type I or II
- ☐ Emphysema
- ☐ Epilepsy/Fainting Spells/Seizures
- ☐ Glaucoma
- ☐ High or Low Blood Pressure
- ☐ Hepatitis, Jaundice or Liver Disease
- ☐ Kidney Disease or Kidney Problems
- ☐ G.E. Reflux/Persistent Heartburn
- ☐ Rheumatoid Arthritis
- ☐ Sleep Disorder/Snoring/Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis

Allergies:
Aspirin _____
Penicillin _____
Local Anesthetic_____
Codeine_____
Sulfa_____
Sedatives_____
Metals_____
Latex_____
Iodine_____
Other_____
_____
_____
_____

Other Illnesses_____

Pregnant ?_____ Number of Weeks_____ Nursing?_____

Name of Physician_____ Date of Last Exam_____

Current Medications_____

_____

The information given is accurate and complete to the best of my knowledge. I will not hold Dr. Valentine or any of his staff responsible for any errors I may have made in completion of this form.

Signature_____ Date_____

(For future use) Only initial if there have been no changes to your medical history

Initials_____Date_____ Initials_____Date_____ Initials_____Date_____