HALLMARK Dentistry

Health History Questionnaire **Today's Date:_____**

Name: _____ SS#:_____

Street Address: _____

City: _____ State: _____ Zip:_____

Phone: (home)_____ Cell:_____ Work:_____

Insurance Co: _____ **Contract ID:**_____ **Subscriber DOB**:_____

Date of Birth: _____ Sex: Male or Female Occupation:_____

Emergency Contact: _____ Phone: _____

Please circle any of the following that apply:

High/Low Blood Pressure	Systemic Lupus	Epilepsy/ Neurological Disorders
Joint Replacement	Asthma	Diabetes
Osteoporosis	Cancer/Chemo/Radiation	Seizures
Cardiovascular Disease	Reflux/Persistent Heartburn	Mental Health Disorder
Pacemaker	Gastrointestinal Disease	Migraines
Congestive Heart Failure	Liver Disease/Hepatitis	Recurrent Infections
Arteriosclerosis	Kidney Problems	Ulcers
Heart Attack	Sexually Transmitted Disease	Malnutrition
Other Congenital Heart Defects	Glaucoma	Hemophilia
Tuberculosis	Arthritis	Rheumatic Fever
Paget's Disease	AIDS or HIV Infection	Rheumatic Heart Disease
Autoimmune Disease	Anemia	Emphysema
Thyroid Problems	Stroke	Chronic Pain
Smoking	Pregnant	Controlled Substances

Please explain any above, or if you have anything not mentioned above:

_____

_____

_____

Current Medications: (include vitamins, natural or herbal preparations and/or diet supplements)

_____
_____
_____

Allergies – Are you allergic to or have you had a reaction to:

Local Anesthetics	Yes/No
Aspirin	Yes/No
Penicillin or other antibiotics	Yes/No
Barbiturates, sedatives, or sleeping pills	Yes/No
Sulfa drugs	Yes/No
Codeine or other narcotics	Yes/No
Metals	Yes/No
Latex	Yes/No
Iodine	Yes/No

Other:_____

Have you had any of the following conditions?

Artificial (prosthetic) heart valve	Yes/No
Previous Infective Endocarditis	Yes/No
Damaged valves in transplanted heart	Yes/No
Congenital heart disease (CHD)	
Unrepaired, cyanotic CHD	Yes/No
Repaired (Completely) in last 6 months	Yes/No
Repaired CHD with residual defects	Yes/No

What is the reason for your visit today? _____

How do you feel about your smile? _____

Date of your last dental exam: _____

What was done at that time? _____

Date of last dental x-rays:_____

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of her staff, responsible for any action they take or do not take because of errors of omissions that I may have made in the completion of this form.

Signature or Patient/Legal Guardian:_____ Date:_____