WILLIAM F. STRAKA, D.D.S., P.A.

Name _____ (Last / First / Middle) Home Phone ( ) _____ Business Phone ( ) _____

Address _____ (P.O. Box or Mailing address) City _____ State _____ Zip Code _____

Occupation _____ Height _____ Weight _____ Date of Birth ___/___/___ Sex ☐ M ☐ F

Emergency Contact _____ Relationship _____ Phone ( ) _____

If you are completing this form for another person, what is your relationship to that person? _____ (Name / Relationship)

For the following questions, please (X) whichever applies, your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Dental Information

Yes	No		Yes	No	
☐	☐	Do your gums bleed when you brush?	☐	☐	Have you ever had orthodontic (braces) treatment?
☐	☐	Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	Do you have headaches, earaches or neck pains?
☐	☐	Have you had any periodontal (gum) treatments?	☐	☐	Do you wear removable dental appliances?
☐	☐	Have you had a serious/difficult problem associated with any previous dental treatment? If so, explain _____			

How would you describe your current dental problem? _____

Date of your last dental exam _____ Date of last dental x-rays _____

What was done at that time? _____

How do you feel about the appearance of your teeth? _____

Medical Information

Yes	No	
☐	☐	Are you in good health?
☐	☐	Has there been any change in your general health within the past year?

Do you have any of the following diseases or problems: **If you answer yes to any of the 3 items below, please stop and return this form to the receptionist.**

☐	☐	Active Tuberculosis
☐	☐	Persistent cough greater than a 3 week duration
☐	☐	Cough that produces blood
☐	☐	Are you now under the care of a physician? If so, what is/are the condition(s) being treated? _____ Date of last physical examination _____
		Physician(s) _____ (NAME / PHONE / ADDRESS / CITY/STATE/ZIP) _____ (NAME / PHONE / ADDRESS / CITY/STATE/ZIP)
☐	☐	Have you had any serious illness, operation, or been hospitalized in the past 5 years? If so, what was the illness or problem? _____
☐	☐	Are you taking or have you recently taken any medicine(s) including non-prescription medicine? If so, what medicine(s) are you taking? Prescribed _____ Over the counter _____ Natural or herbal preparations _____
☐	☐	Are you taking, or have you taken, any diet drugs such Pondimin (fendluramine), Redux (dexphenfluramine) or phen-fen (phentermine)?
☐	☐	Do you drink alcoholic beverages? If yes, how much alcohol did you drink in the last 24 hours? _____ In the past month? _____ If yes, _____# of drinks per day for _____# of years
☐	☐	Are you alcohol and/or drug dependent? If so, have you received treatment? (Check one) ☐ Yes ☐ No
☐	☐	Do you use drugs or other substances for recreational purposes? If yes, please list _____ Frequency of use (daily, weekly, etc.) _____ Number of years of recreational drug use _____
☐	☐	Do you use tobacco (smoking, snuff, chew)? If so, how interested are you in stopping? (Check one) ☐ Very ☐ Somewhat ☐ Not interested
☐	☐	Do you wear contact lenses?

Allergies Are you allergic to or have you had a reaction to: (Please fill out both columns)

Yes	No		Yes	No	
☐	☐	Local anesthetics	☐	☐	Latex
☐	☐	Aspirin	☐	☐	Iodine
☐	☐	Penicillin or other antibiotics	☐	☐	Hay fever/seasonal
☐	☐	Barbiturates, sedatives, or sleeping pills	☐	☐	Animals
☐	☐	Sulfa drugs	☐	☐	Food (Specify) _____
☐	☐	Codeine or other narcotics	☐	☐	Other (Specify) _____

To yes responses, specify type of reaction _____

Please complete both sides

Yes	No	(Women Only)
☐	☐	Are you pregnant?
☐	☐	Nursing?
☐	☐	Taking birth control pills?

☐	☐	Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? If so when was this operation done? _____
☐	☐	Have you had any complications or difficulties with your prosthetic joint?
☐	☐	Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? If so, what antibiotic and dose?

Name of physician or dentist* _____ Phone _____

Please (X) if you have or had any of the following diseases or problems.

Yes	No	
☐	☐	Abnormal bleeding
☐	☐	AIDS or HIV infection
☐	☐	Anemia
☐	☐	Arthritis
☐	☐	Rheumatoid arthritis
☐	☐	Asthma
☐	☐	Blood transfusion
		If yes, date _____
☐	☐	Cancer/chemotherapy/radiation treatment
☐	☐	Cardiovascular disease.
☐	☐	If yes, specify below:
		○ Angina
		○ Arteriosclerosis
		○ Artificial heart valves
		○ Coronary insufficiency
		○ Coronary occlusion
		○ Damaged heart valves
		○ Heart attack
		○ Heart murmur
		○ High blood pressure
		○ Inborn heart defects
		○ Mitral valve prolapse
		○ Pacemaker
		○ Rheumatic heart disease
☐	☐	Chest pain upon exertion
☐	☐	Chronic pain
☐	☐	Persistent diarrhea

Yes	No	
☐	☐	Disease, drug or radiation-induced immunosurpression
☐	☐	Diabetes. If yes, specify below:
		○ Type I (insulin dependent)
		○ Type II
☐	☐	Dry mouth
☐	☐	Eating disorder.
☐	☐	If yes, specify _____
☐	☐	Epilepsy
☐	☐	Fainting spells or seizures
☐	☐	G.E. reflux
☐	☐	Glaucoma
☐	☐	Hemophilia
☐	☐	Hepatitis, jaundice or liver disease
☐	☐	Recurrent infections
☐	☐	Indicate type of infection
☐	☐	_____
☐	☐	Kidney problems
☐	☐	Low blood pressure
☐	☐	Mental health disorders,
		If yes, specify below:
		_____
		_____
☐	☐	Malnutrition
☐	☐	Migraines
☐	☐	Night sweats

Yes	No	
☐	☐	Neurological disorders,
		If yes, specify _____
☐	☐	Osteoporsis
☐	☐	Persistent swollen glands in neck
☐	☐	Respiratory problems.
		If yes, specify below:
		○ Emphysema
		○ Bronchitis, etc.
☐	☐	Severe headaches
☐	☐	Severe or rapid weight loss
☐	☐	Sexually transmitted disease
☐	☐	Sinus trouble
☐	☐	Sleep disorder
☐	☐	Sores or ulcers in the mouth
☐	☐	Stroke
☐	☐	Systemic lupus erythematosus
☐	☐	Thyroid problems
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Excessive urination
☐	☐	Do you have any disease, condition, or problem not listed above that you think I should know about? Please explain:
		_____
		_____
		_____

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. 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 his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

_____
Signature of Patient/Legal Guardian Date

For completion by dentist

Comments on patient interview concerning health history _____

_____

_____

_____

_____

_____

_____
Signature of Dentist

_____
Date

Health History Update: On a regular basis the patient should be questioned about any medical history changes, date and comments notated, along with signature.

Date	Comments	Signature of patient and dentist
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____