Roland S. Davies, D.D.S.
RESTORATIVE AND COSMETIC DENTISTRY

WELCOME TO OUR OFFICE

We are a health centered dental practice. Thus, we are concerned with your total well-being, not just your oral health. An essential part of our approach is a thorough health story. Please fill out the health questionnaire below completely- even if some questions may not seem relevant to your dental health. Thank you!

What are your hobbies or special interests? (i.e.: sports self improvement, education) _____

_____

Please circle either Y (yes) or N (no) as applicable

Do you have or ever had any of the following?

Hypoglycemia, Diabetes	Y/N	Prosthetic Valves, Joints, or Implants	Y/N
Heart Attack or Heart Trouble	Y/N	Stroke	Y/N
Hay Fever, Asthma, Allergies	Y/N	Heart Murmur, Mitral Valve Prolapse	Y/N
High Blood Pressure	Y/N	Rheumatic Fever	Y/N
Circulatory Problems	Y/N	Anemia, Blood Disorder	Y/N
Hepatitis, Jaundice	Y/N	Excessive Bleeding	Y/N
Lung Problems, Tuberculosis	Y/N	Fainting, Blackouts	Y/N
Epilepsy, Seizures	Y/N	Nervous Disorder	Y/N
Blood Transfusions	Y/N	Headaches, Migraines	Y/N
Facial or Head Injuries	Y/N	Kidney Problems	Y/N
Radiation, Chemotherapy	Y/N	Glaucoma, Eye Problems	Y/N
Malignancies, Cancer	Y/N	Ulcers, Digestive Problems	Y/N
Sinus Problems	Y/N	History of Eating Disorder	Y/N
AIDS, ARC	Y/N	Are you Pregnant now?	Y/N
HIV Positive	Y/N	Other_____	
Arthritis or Rheumatism	Y/N	Blood Pressure_____	

Name, phone of physician _____Date of last physical ____/_____/___

Have you been hospitalized in the last two years? Y/N If yes, explain_____

_____

Do you need a referral for a physician or specialist? Y/N

Do you consume alcohol or use tobacco ? Y/N In what quantities?_____

Have you had unfavorable reactions to any of the following? (Please circle)

Aspirin Codeine Anesthetics Xylocaine Novacaine Sedatives Penicillin Erythromycin Other Antibiotics

Other Drugs_____

Please list any drugs currently taken_____

Reason for this dental visit_____

Date of last dental visit_____ What was done at that time_____

Have you ever been treated by a periodontist, orthodontist, or endodontist? Y/N If yes, please explain_____

_____ Date of last x-rays____/_____/____

Are you happy with the appearance of your teeth? Y/N

Have you noticed any of the following?		Recurring sore in or around the mouth	Y/N
Teeth tender when chewing	Y/N	Jaw clicking or popping	Y/N
Discomfort in face, head, neck, jaw	Y/N	Loose teeth	Y/N
Food caught between teeth	Y/N	Swelling, lumps in mouth	Y/N
Bleeding or sore gums	Y/N	Do you need nitrous, oral, or IV sedation	
Sensitivity to sweets, hot or cold	Y/N	for dental visits	Y/N

Have you had any complications with previous dental treatment? Y/N If so, please explain _____

_____

The information above is correct to the best of my knowledge

Signature_____Date_____

(please complete both sides)

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