

Patient Name:

David J. Shock, DDS Health History

Sex	M	F	Height _____	Weight _____	Single _____	Married _____
Do you have any current health problems?.....Yes No					Please explain any 'yes' answers from left:	
Have you been hospitalized in the past 5 years?.....Yes No						
Are you currently under the care of a physician?..... Yes No						
Physician's Name: _____			Phone # _____			
Address _____						

For the following 30 questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential. 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.

Do you have or have you had any of the following diseases or problems?

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| <ol style="list-style-type: none"> 1. Damaged heart valves, including heart murmur, mitral valve prolapse or rheumatic heart disease?.....Yes No 2. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency coronary occlusion, high or low blood pressure, arteriosclerosis, stroke).....Yes No <ol style="list-style-type: none"> a. Do you have chest pains upon exertion?..... Yes No b. Are you ever short of breath after mild exercise or when lying down?.....Yes No c. Do your ankles swell?.....Yes No d. Do you have inborn heart defects?.....Yes No e. Do you have a cardiac pacemaker?.....Yes No 3. Allergy, Sinus trouble.....Yes No 4. Asthma.....Yes No 5. Osteoporosis, Osteopenia.....Yes No 6. Fainting spells or seizures.....Yes No 7. Persistent diarrhea or recent weight loss.....Yes No 8. Diabetes.....Yes No 9. Hepatitis, jaundice, or liver disease.....Yes No 10. AIDS or HIV infection.....Yes No 11. Thyroid problems.....Yes No 12. Respiratory problems, emphysema, bronchitis, etc.....Yes No | <ol style="list-style-type: none"> 13. Arthritis or painful, swollen joints..... Yes No 14. Joint replacement surgery..... Yes No 15. Stomach ulcer or hyperacidity..... Yes No 16. Kidney Trouble..... Yes No 17. Tuberculosis..... Yes No 18. Persistent cough or cough that produces blood..... Yes No 19. Persistent swollen glands in neck..... Yes No 20. Sexually transmitted disease..... Yes No 21. Epilepsy or other neurological disease..... Yes No 22. Problems with mental health..... Yes No 23. Cancer..... Yes No 24. Treatment for a tumor or growth..... Yes No 25. Problems of immune system..... Yes No 26. Abnormal bleeding..... Yes No 27. Any blood disorder such as anemia..... Yes No 28. Drug dependency..... Yes No 29. Do you use tobacco..... Yes No 30. Women: <ol style="list-style-type: none"> a. Are you pregnant?..... Yes No b. Are you nursing?..... Yes No c. Are you taking birth control pills?..... Yes No |
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Are you allergic or have you had a reaction to any of the following medications or materials: Yes (circle which) No	Please list all medications drugs and pills (including non-prescription) which you are now taking or have taken in the past two years:												
<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%;">Aspirin</td> <td style="width:33%;">Penicillin</td> <td style="width:33%;">Local Anesthetic</td> </tr> <tr> <td>Codeine</td> <td>Erythromycin</td> <td>Novocaine</td> </tr> <tr> <td>Vicodin</td> <td>Tetracycline</td> <td>Xylocaine</td> </tr> <tr> <td>Sulfa drugs</td> <td>Latex</td> <td>Acrylic</td> </tr> </table>	Aspirin	Penicillin	Local Anesthetic	Codeine	Erythromycin	Novocaine	Vicodin	Tetracycline	Xylocaine	Sulfa drugs	Latex	Acrylic	
Aspirin	Penicillin	Local Anesthetic											
Codeine	Erythromycin	Novocaine											
Vicodin	Tetracycline	Xylocaine											
Sulfa drugs	Latex	Acrylic											
Are you allergic to any other medications? Yes No If so, what? _____													

Do you have any disease, condition, or problem not listed above that you think Dr. Shock should know about? Yes No
If so, please explain: _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold Dr. Shock or any of his staff responsible for any errors or omissions that I may have made in the completion of this form. If I have any changes in my health status or if my medications change, I will inform Dr. Shock and his staff at the next appointment.

Patient Signature (Parent of child) _____ Date: _____

Reviewed by Dr. Shock: Date:	Notes:
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