BEAUFORT-JASPER-HAMPTON
COMPREHENSIVE HEALTH SERVICES, INC.

NAME:____

CHART #:______________________________________

DOB:____

DATE:____

DENTAL HEALTH HISTORY PART I

Reason for today's visit:____

Date of last visit to a Dentist:___________________________________

Have you ever had difficulties associated with dental treatment? Yes_____ No_____

Have you been hospitalized in the last three years? Yes_____ No_____

If so, list date and reason:

____

____

____

Date of last physical examination:_____________________________________

Are you presently under the care of a physician? Yes_____ No_____

Are you taking any medications? Yes_____ No_____

Medications:	How often do you take the medications:
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

*List any additional medications on the back

Are you allergic to:	Dental Anesthetics	Yes_____	No_____
	Penicillin or other Antibiotics	Yes_____	No_____
	Aspirin	Yes_____	No_____
	Other Drugs (List)	Yes_____	No_____
	______________________________		
	______________________________		
	Do you smoke or chew Tobacco?	Yes_____	No_____
	Are you on blood thinners and/or aspirin?	Yes_____	No_____
	Have you been tested for HIV/AIDS?	Yes_____	No_____
	If yes, would you like the test redone?	Yes_____	No_____
	If no, would you like to be tested?	Yes_____	No_____
Women:	Are you pregnant?	Yes_____	No_____

FORM NUMBER: DEN-DHH-401

BEAUFORT-JASPER-HAMPTON
COMPREHENSIVE HEALTH SERVICES, INC.

NAME:____

CHART #:______________________________________

DOB:____

DATE:____

DENTAL HEALTH HISTORY --PART II

DO YOU HAVE OR HAVE YOU HAD:

ILLNESS	YES	NO	ILLNESS	YES	NO
Rheumatic Fever or Rheumatic Heart Disease			Shortness of Breath		
			Arthritis		
Stroke or Circulative Problems			Artificial Joints/Artificial Heart Valves		
Heart Valve Problems/Surgery			Diabetes		
Angina (Chest Pain Upon Exertion)			Hepatitis		
Heart Trouble/Congestive Heart Failure			Swelling Ankles		
Mitral Valve Prolapse			Lupus		
High Blood Pressure			Allergies		
Heart Murmur			Seizures/Epilepsy		
Stomach Ulcers			AIDS/HIV Positive		
Gland Problems			Liver Disease		
Kidney Problems/Renal Failure			Tuberculosis		
Glaucoma			Cancer or Tumors		
Venereal Disease			Sinus Trouble		
Fever Blisters or Cold Sores			Yellow Jaundice		
Blood Disorders (i.e.Anemia, Prolonged Bleeding, Hemophilia, Leukemia)			Blood Transfusion in Past 5 Years		
			Gout		
Fainting or Dizziness			Alcoholism		
Pain or Noise in Jaw			Emotional Disorders		
Thyroid Problems			Asthma/Emphysema		
Any Teeth Loose, Sensitive			Frequent Headaches		
Substance Abuse			Sickle Cell Anemia		

INDICATE ANY DISEASE, CONDITION, OR PROBLEM NOT LISTED ABOVE THAT YOU THINK THE DENTIST SHOULD KNOW ABOUT:____

To the best of my knowledge, the provided medical and dental history is correct. I consent to such examinations, x-rays, and diagnostic procedures and tests that may be prescribed. In addition, I consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of oral sedatives or local anesthetic and indicated photos, and releasing information to my insurance company.

Patient's (Parent's) Signature | Date

Dentist Signature | Date