ATTACHMENT I



Dental Health History

Name	and the same and t
ID No.	
Birthdate	

In the following questions, circle Yes or No. whicheve

****		naturo	of Denti	st Date		
Comme	ents by Dentist:					
	(If patient is a child, parer	nt or 1	egal gua	rdian must sign) Relationship		
and s	ignificant risk factors associated with	n this	treatmen	explained to my satisfaction.		
-	I also understand that before treatment	t is pr	ovided,	I have the right to have the the benefits, alte	ernative	s,
knowl been	edge. I have asked for an explanation	of any	my dent	pestions and have answered the questions to the words) that I did not know (if any), and my que sist, or any of his/her staff, responsible for a orm.	estions	have
7. Are you (PATIENT) currently having any dental pain or problem? If yes, describe.						No
				*	Yes	No
	ave you (PATIENT) ever experienced any ental treatment? If yes, describe				Vac	No
au	re you (PATIENT) allergic to or ever ex nesthetic (novocain), penicillin, or a ainting. If yes, describe.	ny drug	s/pills?		Yes	No
4. Are you (PATIENT) currently taking any medication, pills or drugs? If yes, list.						No
3. Have you (PATIENT) been hospitalized in the last 2 years? If yes, why?						No
2. Are you (PATIENT) currently under care of a physician (doctor)? If yes, list name of doctor.						No
	Emotional Problems	Yes	No	Other	Yes	No
	Thyroid Problems	Yes	No	Painful or Swollen Joints	Yes	No
	Asthma	Yes	No	Trimester 1 2 3		
	Allergies or Skin Rash	Yes	No	Pregnancy	Yes	No No
	Blood Tranfusions	Yes	No	AIDS/ARC/HIV Positive Cancer	Yes	No
	Excessive Bleeding or Bruise Easily	Yes	No No	Venereal Disease	Yes	No
	Anemia or Blood Problems Sickle Cell Anemia	Yes	No	Liver Problems or Hepatitis	Yes	No
	Stroke	Yes	No	Kidney Problems or Excessive Urination	Yes	No
	Fainting or Dizzy Spells	Yes	No	Epilepsy or Seizures	Yes	No
	High or Low Blood Pressure	Yes	No	Diabetes or Excessive Thirst	Yes	No
	Heart Trouble or Shortness of Breath	Yes	No	Tuberculosis (TB) or Persistent Cough	Yes	No
	Rheumatic Fever or Heart Murmur	Yes	No	Neurological Problems	Yes	No
	o you (PATIENT) have or have you (PATI	Latt) III	d enty of	the following.		

DH 3117, 10/96 (Part 5) (Replaces HRS-H Form 3117, part 5, which may be used) (Stock Number: 5744-005-3117-7)