Health Questions **Robert M. Dutton, DDS** **Today's date**_____

Name (last, first)_____ **Date of birth**_____ **Sex M F** **SSN**_____

Phone numbers-Home_____ **Work**_____ **Cell**_____

Marital status_____ **Occupation**_____ **Email**_____

Address (complete)_____

Physician's name and address_____

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

Y or N **Congenital heart disease**
Y or N **Heart disease e.g. high blood pressure, infarct, artificial heart valve**
Y or N **Central nervous disorder, including stroke**
Y or N **Neurologic illness e.g. epilepsy, seizures, etc.**
Y or N **Psychiatric disorder e.g. depression, bipolar disorder, etc.**
Y or N **Lung disease e.g. tuberculosis, pneumonia**
Y or N **Asthma, hay fever, sinusitis**
Y or N **History of smoking cigarettes, cigars, pipe smoking or snuff**
Y or N **Osteoporosis or osteopenia**
Y or N **Diabetes**
Y or N **Stomach and bowel disease including ulcers, etc.**
Y or N **Liver disease e.g. hepatitis or jaundice**
Y or N **Blood disease e.g. anemia, leukemia, thrombocytopenia, abnormal blood count**
Y or N **Infectious disease including venereal**
Y or N **Arthritis**
Y or N **Hip, knee or other joint replacement --if yes when did you receive it**
Y or N **Cancer**
Y or N **Other diseases or illnesses not listed above**

Circle any of the following drugs or medications you are taking:

antibiotics / anticoagulants / blood pressure medication / chemotherapy drugs / digitalis / steroids / tranquilizers / diabetic medications / sedatives / osteoporosis medication / antihistamines / anti-depressants / diet pills / other drugs

Circle any of the following that you are allergic to:

penicillin / sulfas / tetracycline / clindamycin / iodine / local anesthesia / latex / sedatives / aspirin / codeine / any allergies not listed above?