Sequoia Dental Office
5601 W. Hillsdale
Visalia, CA 93291
Tel: (559) 635-7186
www.sequoiadental.com

Patient Number____________________

HEALTH HISTORY

Patient's Name ____
Last First Initial Date of Birth (mm/dd/yy)

CHECK THE APPROPRIATE ANSWER:

❑ Yes ❑ No Are you being treated by a physician now?
If yes, please explain: ______________________________

❑ Yes ❑ No Are you taking any medication now?
If yes, please explain: ______________________________

❑ Yes ❑ No Have you had a serious illness, operation or been hospitalized in the last five years?
If yes, please explain: ______________________________

❑ Yes ❑ No Have you had serious problems with any previous dental treatment?
If yes, please explain: ______________________________

❑ Yes ❑ No Do you have any allergies?
❑ Foods ❑ Latex ❑ Metals, Jewelry
❑ Anesthetics ❑ Medication or Drugs, please specify: ______________
❑ Other: ______________________________

Date of last physical exam: ______ / ______ (mm/yy) Date of last dental exam: ______ / ______ (mm/yy)

CHECK IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING AILMENTS:

- ❑ HIV / AIDS
- ❑ Kidney, bladder disease
- ❑ Arthritis, rheumatism
- ❑ Respiratory diseases
- ❑ High blood pressure
- ❑ Stomach problems, ulcers
- ❑ Diabetes
- ❑ Thyroid, adrenal disease
- ❑ Heart Problems
- ❑ Tumors, cancer
- ❑ Rheumatic fever
- ❑ Hepatitis, other liver diseases
- ❑ Arteriosclerosis
- ❑ Blood disorders (e.g. leukemia, anemia)
- ❑ Family history of diabetes, heart problems, tumors
- ❑ Lung diseases (e.g. asthma, emphysema, tuberculosis)

FEMALE PATIENT ONLY:

❑ Yes ❑ No Are you or could you be pregnant or nursing?
❑ Yes ❑ No Are you taking birth control pills?
❑ Yes ❑ No Do you have any problem related to your menstrual period?

ALL PATIENTS:

❑ Yes ❑ No Do you have or have you had any other disease or medical problem NOT listed on this form?

If yes, please explain:

____

____

____

I certify that the above information is complete and accurate to the best of my knowledge. I understand that it is my responsibility to inform this office of any change in my medical status.

PATIENT or GUARDIAN SIGNATURE ______________________________ DATE ______________

DENTIST SIGNATURE ______________________________ DATE ______________

© Transcendent International, LLC.