HEALTH HISTORY

FRANK L. MAMS, DDS
ASHLEY L. SWECKER, DDS
600 S. RANDOLPH AVE., ELKINS, WV
304-636-5800

DATE_____

Name_____ _____ _____
LAST FIRST M.I.

Address_____
NUMBER AND STREET CITY STATE ZIP CODE

Home Phone _____Business Phone _____Single__Married__Name of Spouse _____

Date of Birth_____ Sex_____ Height_____ Weight_____ Occupation_____

Name of Person to contact in case of Emergency_____ Phone_____

If you are completing this form for another person, what is your relationship to that person?_____

Referred By:_____

PLEASE ANSWER EACH QUESTION

1. Have you been a patient in a hospital during the past 2 years? **YES NO**

2. Have you been under the care of a physician during the past 2 years? **YES NO**

3. Have you taken any kind of medicine or drugs during the past year? **YES NO**

4. Are you currently taking medications? If so, please list, including birth control pills:

_____

_____

5. Are you or anyone in your family allergic to local anesthetics? **YES NO**

6. Are you allergic to penicillin or any drugs or medicine? **YES NO**

Please list_____

7. Have you ever had any excessive bleeding requiring special treatment? **YES NO**

8. Do you use tobacco? **YES NO**

Smoke?_____ Chew?_____

9. CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE NOW OR HAVE HAD:

Hepatitis	**Joint Replacement**	**Chronic Cough**	**Tuberculosis**
Rheumatic Fever	**Venereal Disease**	**HIV Positive**	**Arthritis**
Stroke	**Heart Valve Problems**	**Stomach Problems**	**Jaundice**
Epilepsy	**High Blood Pressure**	**Fainting Spells**	**Anemia**
Psychiatric Treatment	**Sinus Problems**	**Heart Trouble**	**Asthma**
Diabetes	**Heart Murmur**	**Cancer**	**Angina**
Renal Problems			

Continue on next page

10. Have you had any other serious illness? **YES NO**

Explain_____

11. (Women) Are you pregnant now? **YES NO**

12. (Women) Are you nursing? **YES NO**

13. Do you have any condition or problem not listed above that you think we should know? **YES NO**

Explain_____

14. Are you wearing contact lenses? **YES NO**

15. Are you wearing any removable dental appliances (dentures or retainers)? **YES NO**

16. Have you ever had orthodontic treatment (braces or removable appliances)? **YES NO**

17. (Children) Has your child ever been seen by a dentist? **YES NO**

18. (Children) Does your child suck their fingers or thumb **YES NO**

19. Do you snore? **YES NO**

20. Has anyone ever told you that you snore? **YES NO**

21. Have you ever had or been requested to have a sleep study? **YES NO**

22. Have you ever been diagnosed with Sleep Apnea? **YES NO**

If Yes, do you have a night time device to use for sleep problems? **YES NO**

23. Does your jaw joint (TMJ) hurt? **YES NO**

24. Does your jaw joint click or pop when opening or chewing**? YES NO**

25. Do you clench or grind your teeth at night? **YES NO**

26. Do you clench or grind your teeth at other times? **YES NO**

27. Do you have dental insurance? **YES NO**

If so, please provide SS#_____

28. Are you having a dental problem at this time? YES NO

Explain_____

_____

Signature_____
of patient or parent/guardian