DENTISTRY on the VILLAGE GREEN
DR. ROSS M. GILLE

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DentistryontheVillageGreen.com

Health Questionnaire

Date:____/_____/_____

Patient's First Name:_____ Last Name:_____ MI:____

Primary Care Physician's Name:_____

Physician's Address:_____ Physician's Phone #:_____

Are you under a physician's care? No/Yes For what reason_____

Are you taking any medications or drugs? No/Yes Please list_____

Are you allergic to any foods or medications? No/Yes Please list_____

(Women) Are you pregnant? No/Yes Due date_____

Do you smoke or use smokeless tobacco? No/Yes

Do you have, or have you ever had, any of the following? Check all that apply:

___Joint Replacement	**___Asthma**	**___Heart Attack**
___Artificial Joint Infection	**___Pacemaker**	**___Repaired Heart Defect**
___ Stroke	**___HIV Positive/AIDS**	**___Cardiac Transplant**
___ Epilepsy/Seizures	**___High Blood Pressure**	**___Endocarditis**
___ Tuberculosis	**___Herpes (Cold Sores)**	**___Artificial Heart Valve(s)**
___ Hepatitis or Jaundice	**___Prolonged Bleeding**	**___Congenital Heart Defect**
___Diabetes	**___Cancer Treatments**	**___IV Bisphosphonates**

Is there anything else we should know about your medical history? _____

_____

New Patients Only:

When was your last dental checkup? _____

Name & Phone # of your previous dentist_____

Are you having any particular dental problems at this time?

No_____ Yes_____

*****The above information is true to the best of my knowledge:**

_____Signature of Patient (or Legal Guardian)