WOLF DDS

Dental History

Reason for today's visit: ______

Date of last dental visit: ______ Were xrays taken? □ Y □ N

Former Dentists Name: ______

Address: ______
Street City State Zip

Phone: ( ) ______

Do you have severe anxiety about dental treatment? □ Y □ N

Have you ever had an adverse reaction to dental treatment? □ Y □ N

if yes please explain: ______

Health History

Physician's Name ______

Address: ______
Street City State Zip

Phone: ( ) ______

Date of last exam: ______

Are you currently being treated by a physician? □ Y □ N

if yes please explain: ______

Have you been admitted to a hospital or had emergency care in the past two years? □ Y □ N

if yes please explain: ______

Are you currently taking any medications, including oral contraceptives or aspirin? □ Y □ N

if yes please list: ______

Have you had an allergic reaction? □ Y □ N

if yes please list all allergies: ______

Do you or have you used tobacco products? □ Y □ N For how long? ______

Do you consume alcoholic beverages? □ Y □ N How often? ______

Do you have any history of the following diseases or conditions?

- □ Anemia
- □ Arthritis
- □ Asthma
- □ Autism
- □ Bleeding(prolonged)
- □ Brain Injury
- □ Cancer: Type ______
- □ Cerebral Palsy
- □ CleftLip/Palate
- □ Diabetes
- □ Emotional disability
- □ Fainting
- □ Gastrointestinal Disorders
- □ Hearing Loss
- □ Heart Disease
- □ Heart Murmur
- □ Hepatitis/Liver Disease
- □ Herpes
- □ High Blood Pressure
- □ HIV Infections (AIDS)
- □ Jaundice
- □ Lyme Disease
- □ Mental Retardation
- □ Nutritional Deficiency
- □ Orthopedic Problems
- □ Rheumatic Fever
- □ Transfusion of Blood
- □ Scoliosis
- □ Sickle Cell Trait or Disease
- □ Stroke
- □ Syndrome: Type ______
- □ Thyroid Condition
- □ Other

Women only:

Are you Pregnant? □ Y □ N Are you nursing? □ Y □ N

To the best of my knowledge, all of the preceding information is accurate. I understand that it is my responsibilty to inform the Doctors and his staff, if in the future, I have a change in my health status, including changes in my medications and/or allergies.

Signature: ______ Date: ______

Print Name: ______