Please check if you have or have had any of the following:

Anemia		Thyroid disease	
Arthritis		Liver disease	
Artificial heart valve		Pacemaker or defibrilator	
Artificial joint When?		Stroke When?	
Asthma		Tuberculosis	
Allergies (not listed on previous page)		Radiation treatment	
Cancer When?		Chemotherapy	
Type:		Diabetes	
Heart murmur, mitral valve prolapse		HIV or AIDS	
Epilepsy		High blood pressure	
Bleeding problems		Hepatitis Type	
Taken oral or IV bisphosphonate?		Hemophilia	
When? For how long?		Any serious disease or condition not listed here?	
Do you smoke or use tobacco products?		(1)	
Do you drink alcohol? How often?		(2)	

Dental history

What is the main reason you made an appointment with Smile Partners?_____
_____

Are you in pain? YES NO For how long?_____ Where?_____

How long has it been since your last dental visit?_____ Dentist name:_____

Reason for visit: _____

Do you have special concerns about seeking dental care? YES NO

Fear Time Cost Transportation Other?_____

Describe any issues, concerns or problems you may have had with previous dental treatment:___
_____

I have reviewed the information I have provided on this questionnaire. It is accurate to the best of my knowledge. I understand that this information will be used by Smile Partners staff to help determine appropriate and healthful dental disease prevention therapies. I understand that the treatment provided by dental hygienists is for prevention and control of dental disease and that I will be evaluated or referred to a dentist for determination of my other dental needs.

Signature: _____ *Date:*_____