GREATER VALLEY
HEALTH CENTER

GVHC DENTAL HEALTH HISTORY

Patient Name: _____ DOB: _____

Have you been hospitalized or had a serious illness in the last three years?

[ ] YES [ ] NO If YES, WHY? _____

Do you have or have you had?

Heart Disease	[ ] YES [ ] NO
Heart Attack, Stroke	[ ] YES [ ] NO
High Blood Pressure	[ ] YES [ ] NO
Asthma	[ ] YES [ ] NO
Diabetes	[ ] YES [ ] NO
Hepatitis/HIV/AIDS	[ ] YES [ ] NO
Radiation	[ ] YES [ ] NO
Chemotherapy	[ ] YES [ ] NO
Artificial Joint	[ ] YES [ ] NO
Osteoporosis	[ ] YES [ ] NO
Seizures	[ ] YES [ ] NO
Are you pregnant?	[ ] YES [ ] NO
Allergies?	[ ] YES [ ] NO

If you have allergies please list: _____

PLEASE LIST MEDICATIONS (PRESCRIBED OR OVER THE COUNTER) YOU ARE TAKING:
