Gary J. Westerman, D.M.D.

1063 Main St. North, Southbury, CT 06488

Tel: 264-5630

Medical History

Today's Date_____

Name _____ Marital Status: Single____ Married____ Name of Spouse _____
Last First MI

Address _____ City _____ State_____ Zip Code_____

Home Phone _____ Bus _____ Cell _____ Email _____

Date of Birth _____ Sex _____ Height _____ Soc. Sec. # _____ Occupation: _____

Physician's Name and Telephone No. _____

How did you hear about our office? _____

Chief dental problem _____

Other dental concerns? _____

If child, name of parent or legal guardian _____

Do you have dental insurance? _____ Name, Policy # (if known) _____

PLEASE ANSWER ALL QUESTIONS BELOW

In the following questions, circle yes or no, whichever applies.

Your answers are for our records only and will be considered confidential.

1.	Are you in good health?	Yes	No
2.	Has there been any change in your general health within the past year?	Yes	No
3.	Date of last physical examination _____		
4.	Have you had any serious illnesses or operations?	Yes	No
	If yes, describe _____		
5.	Do you smoke, or former smoker? (circle) ..... # packs/day? _____	Yes	No
6.	Heart Problems		
	a. Artificial heart valve, (describe)	Yes	No
	b. History of subacute bacterial endocarditis	Yes	No
	c. Heart attack (Date) _____	Yes	No
	d. Congenital heart lesions	Yes	No
	e. Cardiovascular disease *(circle)*: heart failure, angina, arteriosclerosis, arrhythmia	Yes	No
	f. Pacemaker or implantable defibrillator (describe)	Yes	No
7.	Artificial joint (hip or knee) .....Date of placement	Yes	No
8.	High blood pressure	Yes	No
9.	Stroke or transient ischemic attack (TIA) (describe)	Yes	No
10.	Asthma ..... What causes your asthma? _____ Carry inhaler? _____	Yes	No
11.	Chronic respiratory problems *(specify)* _____	Yes	No
12.	Fainting spells or seizures (circle) ..... What brings these on? _____	Yes	No
13.	Diabetes – (self or immediate family member) (circle)	Yes	No
14.	AIDS, HIV, or other immune suppressive disorders	Yes	No
15.	Hepatitis, jaundice, or liver disease	Yes	No
16.	Tuberculosis	Yes	No
17.	Have you noticed any of the following: Night sweats, bloody sputum, sudden weight loss, or productive, prolonged cough for over 3 weeks duration?	Yes	No
18.	Rheumatoid arthritis or lupus		

19. Kidney disease ..... Yes No
20. Venereal disease ..... Yes No
21. Cancer *(specify)* ..... Yes No
22. Thyroid problems ..... Yes No
23. Abnormal bleeding or blood disorders ..... Yes No
*24. Are you taking any drugs or medications? Including herbal ..... Yes No
If so, what? _____
*25. Allergies (drugs, anesthetics, foods, etc.) Describe your allergic reaction ..... Yes No
Please list _____
26. Are you pregnant? ..... Yes No
27. Other _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Signature of Patient or legal guardian Signature of Dentist