

Health Information and History

Today's Date: _____

Patient's Name: _____

Date of Birth: _____

If you are completing this form for another person:

Your name: _____ Phone: _____ Relationship: _____

Emergency Contact: (If not listed above)

Name: _____ Phone: _____ Relationship: _____

Primary Physician: _____ Phone: _____ Relationship: _____

Date of last physical examination: _____ Date of last blood test/work up: _____

Other Physicians & Specialists

Name: _____ Specialty: _____ Phone: _____ City & State: _____

Name: _____ Specialty: _____ Phone: _____ City & State: _____

1. With in the last 3 years, have you been hospitalized or had surgery? Yes No

If Yes, please give reasons and dates: _____

2. Have you ever been instructed to take ANY medications or take ANY special precautions before any dental appointments*? Yes No

If Yes, please explain: _____

3. Are you taking ANY drugs, medications, or treatments at this time? Yes No

(If you brought a complete written list with you, give that to the receptionist instead)

Prescribed: _____

Over-the-counter (OTC) medications (such as Aspirin, Advil, allergy medication, sleeping aids, etc):

Vitamins, naturals or herbal preparations or chemotherapy treatments*? Yes No

If Yes, for how long? _____ Name of facility performing the treatment: _____

4. Are you taking or have you ever taken/been treated with a Bisphosphonate (Fosamax)? Yes No

5. Are you allergic to or have you ever experienced an unusual reaction to:

___ Latex ___ Metal or jewelry ___ Dental anesthesia (local)

___ Fluoride ___ Nitrous oxide (laughing gas) ___ General anesthesia

6. Are you allergic to or have you ever had any reaction to any of the following drugs?

___ Penicillin (or related drugs) ___ Tranquilizers (Valium) ___ Tetracycline ___ Codeine

___ Aspirin/Ibuprofen (Advil, Motrin, Nuprin) ___ Keflex (Cephalexin) ___ Sulfa drugs ___ Iodine

___ NSAID (Celebrex, Vioxx, Anaprox) ___ Clindamycin (Cleocin) ___ Erythromycin

7. Are you had an allergic reaction or unusual response to ANY other medications, drugs, pills, or treatments?

Yes No

If Yes, please list: _____

Reviewed By: _____

Continued on next page...

Health Information and History (continued)

Patient's Name: _____

8. Do you have, or have you ever had, any of the following? (Please check Yes or No for each question)

	Yes	No		Yes	No
Congenital heart defects	___	___	Asthma	___	___
Angina or chest pains	___	___	Hay fever, skin or food allergies or allergies in general	___	___
Atherosclerosis	___	___	Sinus problems	___	___
Congestive heart failure	___	___	Tuberculosis, emphysema or lung disorder	___	___
Coronary artery disease	___	___	Skin problems	___	___
Heart Surgery	___	___	A sore or wound that bleeds easily does not heal	___	___
If Yes, type & date _____			A thyroid problem or disease	___	___
Heart attack	___	___	Arthritis	___	___
If yes, date _____			Glaucoma or any eye diseases	___	___
Rheumatic heart disease/rheumatic fever	___	___	Epilepsy or other seizure disorder	___	___
Infective Endocarditic*	___	___	Any kidney problems	___	___
Heart valve(s) damage/Mitral valve prolapse	___	___	Ulcers, acid reflux, or stomach problems	___	___
Artificial heart valve	___	___	A compromised immune system (Lupus, HIV, AIDS, radiation immune problems, etc.)	___	___
Pacemaker	___	___	An active sexually transmitted disease (STD)	___	___
Stroke or CVA	___	___	Any mental health issues	___	___
High blood pressure	___	___	Been treated for any psychiatric condition	___	___
Low blood pressure	___	___			
Anemia	___	___	Women Only:	Yes	No
Hemophilia or bleeding disorder	___	___	Are you pregnant	___	___
Excessive bleeding from any cut or incident	___	___	If Yes, what is your due date: _____		
Diabetes or blood sugar problems	___	___	Do you think you might be pregnant	___	___
Any artificial joint, joint surgery, or prosthesis	___	___	Are you presently nursing	___	___
If Yes, what joint or area: _____			Are you using birth control medication	___	___
When was operation done: _____			Are you taking hormone replacement therapy	___	___
Hepatitis, jaundice, or other liver problems	___	___			
Any form of cancer	___	___			
An organ transplant	___	___			

9. Do you have any other conditions, diseases, or medical problems, or is there ANY other information that you would like us to know about, or that we should be made aware of? Yes No

If Yes, please explain: _____

CONSENT - To the best of my knowledge, all of the preceding information is correct and if there is ever any change in health, or medications, this practice will be informed of the changes without fail. I also consent to allow this practice to contact any healthcare provider(s) and to have the patient's health information released to aid in care and treatment. I also hereby consent to allow diagnosis, proper health care and treatment to be performed by this practice for the above named individual until further notice.

I understand there are no guarantees or warranties in health or dental care.

Signature _____ Date _____
 (Parent or guardian, if patient is a minor)

Reviewed By: _____

