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: _____ City & State: _____

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, natural or herbal preparations and/or dietary supplements:

_____

Are you having or have you ever had radiation 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 ___Metals 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) ___Tetra cycline ___Codeine

___Aspirin / Ibuprofen (Advil, Motrin, Nuprin) ___ Keflex (Cephalexin) ___Sulfa drugs ___Iodine

___NSAID (Celebrex, Vioxx, Anaprox) ___ Clindamycin (Cleocin) ___Erythromycin

7. Have you had an allergic reaction or unusual response to ANY other medications, drugs, pills, or treatments? ☐ **Yes** ☐ **No**

If Yes, please list :_____

Continued on next page…

Reviewed By: _____

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
Congenital heart defects	___	___
Angina or chest pains	___	___
Atherosclerosis	___	___
Congestive heart failure	___	___
Coronary artery disease	___	___
Heart surgery If Yes, type & date _____	___	___
Heart attack If Yes, date _____	___	___
Rheumatic heart disease / rheumatic fever	___	___
Heart murmur*	___	___
Heart valve(s) damage / Mitral valve prolapse	___	___
Artificial heart valve	___	___
Pacemaker	___	___
Stroke or CVA	___	___
High blood pressure	___	___
Low blood pressure	___	___
Anemia	___	___
Hemophilia or bleeding disorder	___	___
Excessive bleeding from any cut or incident	___	___
Diabetes or blood sugar problems	___	___
Any artificial joint, joint surgery, or prosthesis If Yes, what join t or area: _____ When was operation done: _____	___	___
Hepatitis, jaundice, or other liver problems	___	___
Any form of cancer	___	___
An organ transplant	___	___

	Yes	No
Asthma	___	___
Hay fever, skin or food allergies or allergies in general	___	___
Sinus problems	___	___
Tuberculosis, emphysema or lung disorder	___	___
Skin problems	___	___
A sore or wound that bleeds easily or does not heal	___	___
A thyroid problem or disease	___	___
Arthritis	___	___
Glaucoma or any eye diseases	___	___
Epilepsy or other seizure disorder	___	___
Any kidney problems	___	___
Ulcers, acid reflux, or stomach problems	___	___
A compromised immune system (Lupus, HIV, AIDS, radiation immune problem, etc.)	___	___
An active sexually transmitted disease (STD)	___	___
Any mental health issues	___	___
Been treated for any psychiatric condition	___	___

Women Only:	Yes	No
Are you pregnant If Yes, what is your due date: _____	___	___
Do you think you might be pregnant	___	___
Are you presently nursing	___	___
Are you using birth control medication	___	___
Are you taking hormone replacement therapy	___	___

	Circle One	
Are you tired during the day?	Yes	No
Do you wake up during the night?	Yes	No

Has anyone mentioned that you snore or have you woken up gasping/choking for air?	Yes	No
Have you ever had a sleep test?	Yes	No
Have you been prescribed a CPAP machine?	Yes	No

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: _____