Health Information and History

Patients Name: ______________________ **Date of Birth:** ______________ **Today's Date:** ______________

If you are completing this form for another person

Your name: ______________________ Phone: ______________ Relationship: ______________

Emergency Contact: (If not listed above)

Name: ______________________ Phone: ______________ Relationship: ______________

1. **Within 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 give explain:

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

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

   Prescribed and for what condition: ______________________

   ____

   Over the counter (OTC) Medicines or vitamins ______________________

   Are you having or have you ever had radiation or chemotherapy treatments? ❑ Yes ❑ No

   If yes, how long: ________ Name of Facility performing treatment: ______________________

4. **Are you taking or have you ever taken / Been treated with a Biophosphate for osteoporosis (e.g. Fosamax)?** ❑ Yes ❑ No

5. **Are you allergic 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 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 (Celbrex, Vioxx, Anaprox) ______ Clindamycin ______ 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: ______________________

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

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?** (If yes, please explain) ❑ Yes ❑ No

   ____

   ____

   ____

CONSENT: To the best of my knowledge, all 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 dental care.

Signature: ______________________ **Date:** ______________

(Parent or guardian, if patient is a minor)

Reviewed by: