

# Health Information



Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Last Physical Date: \_\_\_\_\_

Acct. # \_\_\_\_\_ Physician's Name & Phone #: \_\_\_\_\_

Reason for today's visit? \_\_\_\_\_

Work Related Injury? (circle) **Yes** **No** Have you been under the care of a physician? (circle) **Yes** **No**

Date of last dental visit: \_\_\_\_\_ Have you ever been hospitalized? (circle) **Yes** **No**

Date of last dental x-rays: \_\_\_\_\_ Ever had Novocaine or other local anesthetic? (circle) **Yes** **No**

Are you interested in tooth whitening?(circle) **Yes** **No**

If wearing dentures, age of dentures: \_\_\_\_\_ Are you interested in new dentures? (circle) **Yes** **No**

Are you taking or have taken any steroid/cortisone therapy in the last 2 years? (circle) **Yes** **No**

Are you taking or have taken Oral Bisphosphonates, e.g., FOSAMAX, ACTONEL, BONIVA, or IV Bisphosphonates, e.g., ZOMETA, AREDIA? (circle) **Yes** **No** Taken for how long? \_\_\_\_\_

Have you taken antibiotics prior to dental procedures in the past? (circle) **Yes** **No**

Have you had an adverse reaction or become ill to penicillin, aspirin, codeine, local anesthetics, latex, metals, or any other medication? (circle) **Yes** **No**

List any medications you are allergic to:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_

List any medications you are taking including non-prescription drugs including herbals/vitamins:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_

Do you have a history of:	Y	N		Y	N		Y	N		Y	N
Rheumatic Fever			Asthma			Thyroid Disease			Alcoholism		
Heart Murmur			Allergies or Hives			Epilepsy or Seizures			Psychiatric Treatment		
Mitral Valve Prolapse			Anemia			Fainting or Dizzy Spells			Mouth sores/growths		
Diabetes			Asprin/Anticoagulant Therapy			Ulcers or Stomach Problems			Teeth Grinding/Clenching		
Pace Maker/Heart Surgery			Venereal Disease			Arthritis			Pain in your jaw (TMJ)		
High Blood Pressure			HIV Positive/Aids			Latex Allergy			Any type of Implant		
Low Blood Pressure			Blood Transfusion			Sinus Problems			Any type of Transplant		
Heart Problem ( )			Excessive Bleeding			Cancer (Type: )			Any Artificial Hip, Knee or other Joint		
Stroke			Hepatitis (Type: )			Chemotherapy			Other Disease or Illness:		
Lung Disease			Liver Disease			Radiation Treatment					
Breathing Problems			Kidney Disease			Use of Tobacco Products					
Tuberculosis (TB)			Dialysis			Drug Addiction					

Women	Y	N		Y	N
Is there a possibility of pregnancy?			Are you nursing?		
Estimated Delivery Date: / /			Are you taking any birth control prescriptions?		

**NOTE: Antibiotics ( such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.**

I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_ Dr's. Signature/Medical History Review \_\_\_\_\_ Date \_\_\_\_\_

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