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Health History Form

Patient Name: _____ _____ ___ _____

Last First MI Preferred Name

Your Primary Care Physician's name and phone number:

_____

_____

What is your immediate dental concern today?

_____

_____

Do you take antibiotic premedication for your dental visits? If yes, explain below: * ◯ Yes ◯ No

PREMEDICATION:

_____

_____

WOMEN ONLY: If pregnant, what is your due date? _____

Please indicate if you have experienced any of the following:

☐ 2-hydroxyethyl/Metha	☐ Allergies	☐ Anemia	☐ Anesthetic Allergy
☐ Arthritis	☐ Artific Jts-Premed	☐ Asthma	☐ Augmentin
☐ Blood Disease	☐ Cancer	☐ Codeine Allergy	☐ Diabetes
☐ Dizziness	☐ Epilepsy	☐ Fainting	☐ Fentanyl/Opioid
☐ Glaucoma	☐ Gout	☐ Growths	☐ Hay Fever
☐ Head Injuries	☐ Heart Disease	☐ Heart Murmur-Premed	☐ Hepatitis
☐ High Blood Pressure	☐ High Cholesterol	☐ Hip/Knee Replacement	☐ HIV
☐ Immunodeficiency	☐ Kidney Disease	☐ Latex	☐ Liver Disease
☐ Marcaine Anesthetic	☐ Melanoma Insitu	☐ Mental Disorders	☐ MVP-Premedicate
☐ Nervous Disorders	☐ None Known/NK	☐ Other	☐ Pacemaker
☐ Penicillin	☐ Penicillin Allergy	☐ Pregnancy	☐ Radiation Treatment
☐ Reglan	☐ Respiratory Problems	☐ Rheumatic Fever	☐ Rheumatism
☐ SEPTOCAINE	☐ Sinus Problems	☐ Stomach Problems	☐ Stroke
☐ Sulfa drugs	☐ Tetracycline	☐ Thyroid	☐ Tuberculosis
☐ Tumors	☐ Ulcers	☐ Venereal Disease	

Please explain any "Conditions or Alerts" selected from above:

_____

_____

_____

_____

Any other health issues not listed above?

Any othe allergies not listed above

Please list any medications you are currently taking, one medication per line:

List any CONDITIONS per MEDICATION; use one line per Medication/Condition. (Include prescription and non prescription medications.)

Preferred Pharmacy and Phone Number:

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment below:

Please mark any of the following to indicate Yes in response to the question:

- ☐ Bleeding gums when you brush or floss.
- ☐ Teeth currently causing you pain.
- ☐ Loose teeth or concerned about any teeth loosening.
- ☐ Tooth sensitivity to cold or hot temperatures.
- ☐ Grind your teeth (either consciously or during sleep).
- ☐ Currently have any dental implants, dentures, or partials.

If any of the previous questions are marked yes, please explain:

Patient Name: _____ _____ ____ _____
Last First MI Preferred Name

☐ * **By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes.**

PLEASE SIGN BELOW IF THIS IS A PRINTABLE COPY.

Signature _____ **Date** _____

Response Date: _____