PATIENT HEALTH HISTORY

Your answers are for our records only and will be kept confidential in accordance with applicable laws.
This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Patient Name: _____ Date: _____

Circle Yes or No:

Y N Do you have a medical condition that requires ongoing physician care?
Y N Any recent surgeries (1-5 yrs.)?
Y N Have you had any **joint replacements?**
Y N Do you have heart trouble?
Y N Do you have a **pacemaker**?
Y N Do you have a **heart murmur/mitral valve?**
Y N Do you have **high blood pressure?**
Y N Have you had **by-pass or stint placement** in the last year?
Y N Do you bleed more than normal or take blood thinner?
Y N Are you anemic?
Y N Do you have **diabetes?**
Y N Do you have a suppressed immune system? (i.e. lupus, HIV)
Y N Have you ever had asthma?
Y N Have you had a persistent cough greater than a 3 week duration?
Y N Have you ever had a lung disorder?
Y N Have you ever had radiation treatment?
Y N Have you ever had chemotherapy?
Y N Have you had hepatitis?
Y N Have you ever had tuberculosis?
Y N Have you ever had stomach trouble?
Y N Have you ever had liver disease?
Y N Have you ever had kidney disease?
Y N Do you have a history of seizures?
Y N Do you currently have a shunt (i.e. dialysis)?
Y N Do you have sinus problems?
Y N **Are you allergic to any medications? such as:**
Y N **Novocain?**
Y N **Aspirin?**
Y N **Codeine?**
Y N **Penicillin?**
Y N **Others?**

_____
_____

Y N Do you have a sulfite allergy?_____
Y N Are you allergic to any foods? _____
Y N Are you allergic to latex?
Y N Do you take any decongestants?
Y N Do you take anti-depressant medication?
Y N Have you ever been in a drug or alcohol program?
Y N Are you Pregnant? Due Date_____
Y N Do you currently take any medications? If yes, what?_____

_____
_____
_____
_____
_____

New Patients Only:

Y N Do you have discomfort chewing?
Y N Have you had a cleaning within the last year?
Y N Are you sensitive to hot, cold, or sweets?
Y N Have you had a panoramic or full mouth series of x-rays taken in the last 5 years?
Y N Are you satisfied with your teeth appearance?
Y N Any possibility you may be pregnant?

Other Comments:_____

_____
_____

I acknowledge that the above questions have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Patient Signature: _____ **Date:** _____

Date: **HHx** **BP** **Pulse** **Notes:**

_____
_____
_____
_____
_____
_____