Maywell L Inong DDS ~ General Dentistry

**Patient's Name**_____**Birth date**_____

## Health Information

Medical Doctor _____Phone_____Address_____

Are you currently being treated or have been treated in the last year by a physician or hospitalized? YES NO

If YES, please explain: _____

## List of ALL Drugs, Medications, Over-the-counter Medication, Natural Herbal Remedies:

## Allergies or Sensitivity: (circle all that apply)

| | | |
|---|---|---|
| Metals | Dental Anesthetic | Latex |
| Codeine, or other narcotics | Penicillin or other antibiotic | Other:_____ |
| Aspirin | Barbituates, Sedatives | _____ |

## Do you have or have you had:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Heart Disease | Y N | Diabetes | Y N | Chemotherapy | Y N | Stomach Problems | Y N |
| Heart Attack | Y N | High Cholesterol | Y N | Artificial Joints | Y N | Ulcers | Y N |
| Stroke | Y N | Blood Disorders | Y N | Arthritis | Y N | Epilepsy | Y N |
| Heart Defect | Y N | Bleeding Problems | Y N | Rheumatism | Y N | Seizures | Y N |
| Mitral Valve Prolapse | Y N | Bruise Easily | Y N | Osteoporosis | Y N | Fainting Spells | Y N |
| Heart Murmur | Y N | Liver Disease | Y N | Asthma | Y N | Mental Illness | Y N |
| Pacemaker | Y N | Hepatitis | Y N | Lung Disease | Y N | Bipolar | Y N |
| Artificial Heart Valve | Y N | Kidney Disease | Y N | Sinus Trouble | Y N | Depression | Y N |
| Rheumatic Fever | Y N | Tumors or Cysts | Y N | Eye Disease | Y N | Venereal Disease | Y N |
| Thyroid | Y N | Cancer | Y N | Glaucoma | Y N | AIDS | Y N |
| High Blood Pressure | Y N | Radiation Treatment | Y N | Ear Trouble | Y N | HIV positive | Y N |

## Are you taking or have taken:

Tobacco in any form Yes No Frequency_____

Alcohol Yes No Frequency_____

Fen-Phen or Redux Yes No

Bisphosphonates (ie Fosamax) Yes No

## For Women Only:

Are you or could you be pregnant? Yes No

Delivery Date_____

Are you nursing? Yes No

Are you taking birth control pills/ hormones? Yes No

## All Patients:

Do you require **antibiotic prophylaxis** prior to any dental treatment? Yes No

Do you have or have you had any **other diseases or medical problems NOT listed** on this form? Yes No

If YES, please explain:_____

_____

## Consent for Treatment:

I, the undersigned, have read, understand, and have truthfully answered the above health history. I agree to voluntarily advise Dr. Inong and staff of any change of medical conditions in the future before beginning any dental care. I agree to the release of medical records as needed for dental care. I authorize Dr. Inong and staff to take x-rays, study models, or any other diagnostic aids deemed appropriate by Dr. Inong to make a thorough dental diagnosis. I also authorize Dr. Inong and staff to perform any and all forms of treatment, medication, and therapy that may be indicated with (patient's name) _____'s case. I also understand the use of anesthetic agents embodies a certain risk.

**Signature**_____**Relation to Patient**_____**Date**_____

## Health History Review

**Date**_____ **Signature**_____ **Reviewed by**_____

**Date**_____ **Signature**_____ **Reviewed by**_____

**Date**_____ **Signature**_____ **Reviewed by**_____