HEALTH HISTORY 2021
Linda Lollini DDS, Inc.

Last Name: ____________ First ____________ DOB ____________ Social Security # ____________ M / F

Address: ____________ City: ____________ State: ______ Zip: ______

Phone: (H) ____________ (W) ____________ (C) ____________ Email: ____________

Emergency Contact: ____________ Relationship: ________ Home/Cell Phone: ( ) ____________

Patient's Employer Name: ____________ Referred By: ____________ Spouse's Name: ____________

Physician's Name ________________________________ Physician's Address / Phone # ________________________________

Have you ever had a serious injury to your head or mouth? **Yes / No**

Do you wear dentures or partials? **Yes / No** When were they made? ________________________________

Are you currently experiencing dental pain, discomfort or have dental concerns? **Yes / No** ________________________________

Have you had a serious illness or hospitalizations in the past 5 years? Please list: ________________________________

Are you taking any prescribed medications? Please list: ________________________________

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Please mark and (x) to indicate if you have or have not had any of the following diseases or problems.

	Yes No		**Yes No**		**Yes No**		**Yes No**
Heart Disease…………..	☐ / ☐	Chest pain…………….	☐ / ☐	Arteriosclerosis……….	☐ / ☐	Congestive Heart Failure	☐ / ☐
Damaged Heart Valves	☐ / ☐	Hemophilia………….	☐ / ☐	Heart Murmur……….	☐ / ☐	High Blood Pressure ……..	☐ / ☐
Mitral Valve Prolapse	☐ / ☐	Pacemaker ………….	☐ / ☐	Abnormal Bleeding…..	☐ / ☐	Kidney Problems…………	☐ / ☐
AIDS or HIV Infection	☐ / ☐	Autoimmune disease	☐ / ☐	Rheumatoid Arthritis	☐ / ☐	Osteoporosis………………	☐ / ☐
Emphysema…………….	☐ / ☐	Tuberculosis………..	☐ / ☐			Gastric Reflux…………….	☐ / ☐
Diabetes Type I or II	☐ / ☐	Eating disorder …….	☐ / ☐	Hepatitis List Type ___	☐ / ☐		
Gastrointestinal disease	☐ / ☐	Epilepsy………………..	☐ / ☐				
Thyroid Problems……..	☐ / ☐	Stroke (When) ……..	☐ / ☐	Cancer (Type / Year) …………………………………………………			☐ / ☐
Heart Attack (When)…	☐ / ☐	Neurological Disorders	☐ / ☐	Chemotherapy/Radiation (Type / Year)………………………………			☐ / ☐

Explain the above (yes) marked items or other disorders not listed:

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Allergies (Circle):	Penicillin	Erythromycin	Clindamycin	Amoxicillin
NONE	Local Anesthetic	Metals	Latex	Other (list) ________________

Women: Are you pregnant (# of weeks), attempting to get pregnant, nursing **Yes / No**________________

Premedication:

Have you had a total joint replacement (hip, knee, elbow, finger,…)? **Yes / No**

Have you previously had endocarditis? **Yes / No**

Do you have an artificial heart valve, previous infective endocarditis, damaged heart valves, heart transplant, congenital heart disease (unrepaired, repaired in last 6 months or repaired w/ residual defects)? **Yes / No**

Have you used any medications for osteoporosis or osteopenia, used any antiresorbative agents like Fosamax, Actonel, Boniva, Reclast or have you been treated for Paget's Disease, Multiple myeloma or metastatic cancer with (Aredia, Zometa, XGEVA)? **Yes / No**

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. If I have any changes in my health or medications, I will inform the doctor at my next appointment.

I have been given or shown the offices Dental Materials Fact Sheet and Privacy Practices Policies.

CONSENT:

1. I grant permission for my physician to be contacted for details and advice.
2. I authorize the doctor to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.
3. I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment.
4. I understand that all responsibility is mine for payment for dental services provided in this office for both myself and my dependents, even if I have dental insurance.

Signature of Patient / Legal Guardian: ____ Date: ______________

Signature of Dentist: ____ Date: ______________

If this form is being completed by someone other than the patient or legal guardian, please list your name and connection to the patient.

Name: _______________________________ Relationship: __________________________

Signature: ____ Date: ______________