

PATIENT DENTAL / MEDICAL HEALTH HISTORY

Patient Name: _____ Date of Birth: _____ Date: _____

HEALTH HISTORY

- 1. Are you now, or have you been under the care of a physician during the past two years?..... Yes No
- 2. Are you subject to any nervous disorders or fainting?..... Yes No
- 3. Do you have a Penicillin/amoxicillin drug allergy?..... Yes No
- 4. Do you have any other drug allergies (please list): _____

- 5. Are you taking any blood thinners or subject to prolonged bleeding?..... Yes No
If Yes, what medication are you taking: _____
- 6. Are you taking any medications to treat osteoporosis/Pagets disease (Fosamax, Boniva, Prolia)?.... Yes No
If Yes, what medication are you taking: _____
- 7. Are you using any other medications or drugs?..... Yes No
If yes, what other medications are you taking: _____

- 8. Any History of Addiction?..... Yes No
If yes, please explain _____
- 9. Have you been hospitalized or had any surgery in past 5 years?..... Yes No
- 10. Have you had any other serious illness?..... Yes No
If yes, please explain _____

11. Name of your Medical Doctor: _____ Specialist: _____

12. Women only: Pregnant? How many weeks: _____ Nursing? Yes / No

Circle any of the following which you HAVE HAD and CURRENTLY have:

- | | | |
|-----------------------|--------------------------|------------------------|
| HIV / AIDS | Congenital Heart Failure | Sinus Trouble |
| Anemia | Rheumatic Fever | Tuberculosis |
| Arthritis | High Blood Pressure | Cancer Treatment |
| Asthma | Low Blood Pressure | Kidney Treatment |
| Diabetes | Cardiac Pacemaker | Stroke |
| Artificial Joints | Heart Trouble | Epilepsy |
| Psychiatric Treatment | Heart Murmur | Herpes |
| Hepatitis: A B C | Artificial Heart Valves | Anxiety/Panic Disorder |
| | A-Fib | |

ORAL HEALTH:

- Are you presently having any dental pain?..... Yes No
- Are you aware of any lump, swelling or sore area in your mouth? Yes No
- Are you apprehensive about having dental treatment?..... Yes No
- If you are a NEW patient, when did you last receive dental treatment?.....Date: _____
- Do you use tobacco/vaping products?..... Yes No Do you drink energy drinks?..... Yes No

Permission is hereby granted to the staff of this office for such procedures and anesthesia as necessary for treatment of the undersigned patient.

Patient
Signature: _____

UPDATED ON _____
 UPDATED ON _____
 UPDATED ON _____