

PATIENT HEALTH HISTORY

Your Name: _____ Date of Birth: _____

Physician's Name: _____ Physician's Phone: _____ Medical/Kaiser #: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? Yes No _____
- Have you ever been hospitalized or had a major operation? Yes No _____
- Have you ever had a serious head or neck injury? Yes No _____
- Are you taking any medications, pills, or drugs? (please list)..... Yes No _____
- Do you take, or have taken Phen-Fen or Redux? Yes No _____
- Do you take, or have ever taken Fosamax, if so for how long?..... Yes No _____
- Are you on a special diet? Yes No _____
- Do you use tobacco? Yes No _____
- Do you use controlled substances? Yes No _____
- Do you need to be pre-medicated with antibiotics prior to dental treatment? Yes No _____
- Are you currently taking any blood thinner medication? Yes No _____
- Are you currently wearing a pacemaker? Yes No _____
- Are you able to eat and chew foods satisfactorily? Yes No _____
- Are you experiencing any dental/gum pain or discomfort at this time? Yes No _____
- Are you aware of any clenching or grinding of your teeth? Yes No _____
- Have you ever had any periodontal treatment, such as deep cleaning/root planning or surgery? Yes No _____
- Women: Are you?*
- Pregnant/Trying to get pregnant?..... Yes No _____
- Nursing?..... Yes No _____
- Taking oral contraceptives? Yes No _____

Are you allergic to or have had any reactions to the following?

- | | | | |
|---------------------------------------|---------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Amoxicillin | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Local Anesthetics | <input type="checkbox"/> Vicodin |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Zithromax |
| <input type="checkbox"/> Augmentin | <input type="checkbox"/> Flagyl | <input type="checkbox"/> Sedatives | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Sulfa Drugs | |
| <input type="checkbox"/> Cleocin | <input type="checkbox"/> Iodine | <input type="checkbox"/> Tetracycline | |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Latex | <input type="checkbox"/> Tylenol | |

Do you have or have you had any of the following?

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Thyroid Trouble |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Hay Fever/Allergies | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart/Cardiac Pacemaker | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Renal Dialysis | |
| <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Respiratory trouble | |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Herpes | <input type="checkbox"/> Rheumatic Fever | |

Have you ever had any serious illness not listed above?..... Yes No _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian _____ Date _____