

PATIENT HISTORY FORM

PATIENT INFORMATION

Patient's Name _____ Sex ____ Age ____ Birth Date _____ Height _____ Weight _____

Physician's Name _____ Referring Dentist's Name _____ Reason for Visit _____

PLEASE ANSWER ALL QUESTIONS BY CHECKING YES (Y) OR NO (N)

<p>1. Are you in good health? Y N</p> <p>2. Has there been ANY change in your general health in the past year? Y N</p> <p>3. Date of last physical exam? _____</p> <p>4. Are you now under a physician's care for a particular problem? Y N</p> <p>5. Have you had any serious illness, operations or hospitalizations? Y N If so, describe: _____</p> <p>6. Have you had any adverse effects from dental treatment? Y N</p> <p>7. Do you have or have you ever had:</p> <p style="padding-left: 20px;">A. Cardiovascular Disease, Heart Disease? Y N</p> <p style="padding-left: 20px;">B. Heart Murmur or Rheumatic Heart Disease? Y N</p> <p style="padding-left: 20px;">C. Angina, Chest Pain, or Stroke? Y N</p> <p style="padding-left: 20px;">D. High Blood Pressure? Y N</p> <p style="padding-left: 20px;">E. Heart Pacemaker or Heart Surgery? Y N</p> <p style="padding-left: 20px;">F. Lung Disease, Tuberculosis? Y N</p> <p style="padding-left: 20px;">G. Asthma? Y N</p> <p style="padding-left: 20px;">H. Emphysema, Bronchitis, Pneumonia? Y N</p> <p style="padding-left: 20px;">I. Shortness of Breath, Sleep Apnea? Y N</p> <p style="padding-left: 20px;">J. Seizures, Epilepsy, Convulsions? Y N</p> <p style="padding-left: 20px;">K. Fainting, Dizziness? Y N</p> <p style="padding-left: 20px;">L. Nervous Disorder or Breakdown, Psychiatric Treatment? Y N</p> <p style="padding-left: 20px;">M. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Y N Do You Bruise Easily? Y N</p> <p style="padding-left: 20px;">N. Liver Disease (Jaundice, Hepatitis)? Y N</p> <p style="padding-left: 20px;">O. Kidney Disease? Y N</p> <p style="padding-left: 20px;">P. Diabetes? Y N</p> <p style="padding-left: 20px;">Q. Thyroid Disease (Goiter)? Y N</p> <p style="padding-left: 20px;">R. Arthritis or Bone Diseases? Y N</p> <p style="padding-left: 20px;">S. Stomach Ulcers or Colitis? Y N</p> <p style="padding-left: 20px;">T. Glaucoma or Eye Diseases? Y N</p> <p style="padding-left: 20px;">U. Implants Placed Anywhere in Your Body (Heart Valve, Hip, Knee)? Y N</p> <p style="padding-left: 20px;">V. Radiation (X-Ray) Treatment for Cancer? Y N</p> <p style="padding-left: 20px;">W. Clicking or Popping of Jaw Joint. Difficulty Opening Mouth, Grind or Clench Teeth? Y N</p> <p style="padding-left: 20px;">X. Sinus or Nasal Problems? Y N</p> <p style="padding-left: 20px;">Y. Any Disease, Drugs or Transplant Operation that has Depressed Your Immune System? Y N</p> <p style="padding-left: 20px;">Z. Recurrent Mouth Sores or Body Infections? Y N</p> <p>8. Are using or taking any of the following:</p> <p style="padding-left: 20px;">A. Thyroid Medications? Y N</p> <p style="padding-left: 20px;">B. Antibiotics or Sulfa Drugs? Y N</p> <p style="padding-left: 20px;">C. Anticoagulants (Blood Thinners)? Y N</p> <p style="padding-left: 20px;">D. High Blood Pressure Medicines? Y N</p> <p style="padding-left: 20px;">E. Steroids (Cortisone, Etc.)? Y N</p> <p style="padding-left: 20px;">F. Tranquilizers (Valium, Xanax, Etc.)? Y N</p>		<p>G. Insulin, Diabinese, or Similar Drug? Y N</p> <p>H. Digitalis, Nitroglycerin, Calcium Channel Blockers, or Other Heart Medicine? Y N</p> <p>I. Aspirin or Ibuprofen? Y N</p> <p>J. Marijuana or Other "Street" Drugs? Y N</p> <p>K. Antihistamines or Decongestants? Y N</p> <p>L. Are you taking any other prescribed or over the counter medications? Y N If so, describe: _____</p> <p>M. Have you taken or are currently taking any bisphosphonate medication for osteoporosis, such as Fosamax, Actonel, Boniva or others? Y N If so, describe: _____</p> <p>9. Are you allergic or had bad reaction to:</p> <p style="padding-left: 20px;">A. Local Anesthetic (Novocaine, Etc.)? Y N</p> <p style="padding-left: 20px;">B. Penicillin, Amoxicillin, Cephalosporins or Antibiotics, Etc.? Y N</p> <p style="padding-left: 20px;">C. Barbiturates, Sedatives, Etc? Y N</p> <p style="padding-left: 20px;">D. Aspirin or Ibuprofen? Y N</p> <p style="padding-left: 20px;">E. Codeine or Other Pain Killers? Y N</p> <p style="padding-left: 20px;">F. Latex or Rubber Products? Y N</p> <p style="padding-left: 20px;">G. Food Allergies (Eggs, Dairy) Etc? Y N</p> <p style="padding-left: 20px;">H. Other Allergies or Reactions? Y N If Yes, Please List: _____</p> <p>10. Do you smoke or chew tobacco? Y N How much daily? _____</p> <p>11. Do you use alcohol? Y N How much? _____</p> <p>12. Have you ever sought professional care for drug abuse, alcoholism or emotional disorders? Y N</p> <p>13. Do you have any other conditions not listed above that you think the doctor should know or wish to speak about it privately? Y N If Yes, Please explain: _____</p> <p>14. Women:</p> <p style="padding-left: 20px;">A. Are you taking hormone replacements? Y N</p> <p style="padding-left: 20px;">B. Are you pregnant or planning pregnancy? Y N</p> <p style="padding-left: 20px;">C. Are you nursing? Y N</p> <p style="padding-left: 20px;">D. Are you taking birth control pills? Y N</p> <p style="padding-left: 20px;"><i>*If you are taking birth control pills, the use of antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives for that month's cycle.</i></p> <p style="padding-left: 20px;">Do you understand? Y N</p>
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SIGNATURE OF PERSON COMPLETING INFORMATION	DATE	
MEDICAL UPDATE		
PATIENT'S SIGNATURE	EXCEPTIONS OR CHANGES	DATE
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