Dove Family Dentistry

HEALTH HISTORY

Patient Name: Birth Date: Date Created:

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 medication that you may be taking, c

Are you under a physician's care now?	◯ Yes ◯ No	If yes	
What is the name of your Family Physcian?		Comment	
Emergency Contact: NAME / PHONE / RELATIONSHIP		Comment	
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes	
Are you taking any medications or vitamins?	◯ Yes ◯ No	If yes	
Have you ever been told to take an antibiotic prior to a dental appointment?	◯ Yes ◯ No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No		

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Penicillin	☐ Local Anesthetic	☐ Aspirin	☐ Codeine
☐ Sulfa Drugs	☐ Epinepherine	☐ Advil	☐ Latex
☐ Food Allergies	☐ Seasonal Allergies		

Other? ☐ If yes

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

Heart Disease	◯ Yes ◯ No	Cancer	◯ Yes ◯ No	Joint Replacement	◯ Yes ◯ No	Thyroid Problems	◯ Yes ◯ No
Heart Attack	◯ Yes ◯ No	Lymphoma	◯ Yes ◯ No	Organ Transplant	◯ Yes ◯ No	Autism	◯ Yes ◯ No
Congestive Heart Failure	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Auto Immune Disease	◯ Yes ◯ No	ADD / ADHD	◯ Yes ◯ No
Cardiac Stents	◯ Yes ◯ No	Chemotherapy	◯ Yes ◯ No	HIV / AIDS	◯ Yes ◯ No	Depression	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Radiation	◯ Yes ◯ No	RA	◯ Yes ◯ No	Mood Disorder	◯ Yes ◯ No
A-fib	◯ Yes ◯ No	Stroke	◯ Yes ◯ No	Chronic Fatigue	◯ Yes ◯ No	Bipolar	◯ Yes ◯ No
Heart Murmur	◯ Yes ◯ No	Epilepsy / Seizure	◯ Yes ◯ No	Fibromyalgia	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No
Mitral Valve Prolapse	◯ Yes ◯ No	Vertigo / Fainting Spells	◯ Yes ◯ No	MS	◯ Yes ◯ No	Alcoholism	◯ Yes ◯ No
Pacemaker Placed	◯ Yes ◯ No	Headaches / Migraines	◯ Yes ◯ No	Lupus	◯ Yes ◯ No	Hepatitis A, B or C	◯ Yes ◯ No
Defibrillator Placed	◯ Yes ◯ No	Jaw Pain	◯ Yes ◯ No	Crohn's Disease	◯ Yes ◯ No	Blood Disorder	◯ Yes ◯ No
Angina / Chest Pains	◯ Yes ◯ No	Tobacco Use	◯ Yes ◯ No	Sjorgren's Syndrome	◯ Yes ◯ No	Anemia	◯ Yes ◯ No
High Blood Pressure	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	Parkinson's	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
High Cholesterol	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No	Cold Sores	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Alzheimer's/ Dementia	◯ Yes ◯ No	Asthma	◯ Yes ◯ No	Dry Mouth	◯ Yes ◯ No	Acid Reflux	◯ Yes ◯ No
Liver /Kidney Disease	◯ Yes ◯ No	COPD	◯ Yes ◯ No	Arthritis	◯ Yes ◯ No	Eating Disorder	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Sinus Problems	◯ Yes ◯ No	Psoriatic Arthritis	◯ Yes ◯ No	Hearing Problem	◯ Yes ◯ No
Osteoporosis	◯ Yes ◯ No	Sleep Apnea	◯ Yes ◯ No	Gout	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

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:

X_____ Date:_____