Existing Patient Health History

The information provided on this form is important for your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient/ Preferred name: _____ Gender: _____

Pronouns: _____ Date of birth: _____ Age: _____

Home/ billing address: _____

Street City State Zip

Best phone number: _____ E-mail: _____

Emergency Contact: _____ Phone Number: _____ Relation: _____

Preferred Pharmacy: _____

Medical Update

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

Heart Disease/Problems: _____
- History of heart attack? Y / N When: _____
- Chest pain? Y / N
- Blood pressure? Y / N High or low?_____
- Taking heart medication? Y / N
- Pacemaker? Y / N When: _____
- Endocarditis? Y / N
- Valve replacement? Y / N When: _____
- Mitral valve prolapse? Y / N When: _____
- Heart murmur? Y / N

Stroke? Y / N If yes, when?_____

Blood disease or problems:_____
- Easy bruising? Y / N
- Excessive bleeding? Y / N

Cancer, tumor or radiation? Y / N If yes, please explain:

_____

_____

Fainting spells, seizures, epilepsy? Y / N

Hypo or Hyper thyroid condition? Y / N

Bone or joint problems? Y / N

Joint replacement? Y / N If yes, what joint/ when?_____

_____

New injury of the head, neck or jaw? Y / N

Frequent or severe headaches? Y / N

Asthma/ respiratory problems? Y / N

Hepatitus, jaundice or liver trouble? Y / N

Diabetes? Y / N If yes, Type 1 or Type 2?
- Thirsty or mouth is dry much of the time? Y / N
- Are you insulin dependent? Y / N

Have you recently taken Biphosphonate, Fosamax, Boniva, Actonel or Aredia? Y / N _____

Have you ever taken Suboxone or Buprenorphine? Y / N

_____

History of alcohol, tobacco or chemical dependency? If yes, please explain:

_____

_____

Any allergies or aversion to latex or medications?

_____

_____

Women:

☐ may be pregnant

expected delivery date:_____

☐ Nursing

Do you have a new disease condition or problem not listed above that you feel we should know about? _____

_____

Current medications or medications taken in the last 6 months (including supplements):

_____

_____

_____

I have read the above questions and understand them. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that is have made in the completion of this form. I will notify my dentist of any changes in my medical or dental health.

Signature of patient (or parent): _____ Date: _____

Doctor or hygienist signature: _____