Dental 360

Family & Cosmetic Dentistry

Patient Health History

First Name: ____________________ MI: _____ Last: ________________________ Date of Birth: ______________

Physician's Name: ____________________________________ City: ______________________ State: ____________

When was your last complete physical exam? ____

Circle the appropriate answer and provide details in the space to the right of the question.
Additional space is available on the back of this page.

YES / NO Are you taking any medication or substances? Please list:______________________________

YES / NO Are you allergic to any medication? ____

YES / NO Do you have any other allergies or hives? ______________________________________

YES / NO Do you have problems with penicillin, antibiotics, anesthetics or medications? _______________

YES / NO Are you sensitive to latex? ____

YES / NO Are you pregnant or suspect you may be? ______________________________________

YES / NO Do you use any birth control medications?______________________________________

YES / NO Have you ever been treated for or told you have heart disease? _______________________

YES / NO Do you have a pacemaker, artificial heart valve implant or have been diagnosed with mitral valve prolapse? ____________

YES / NO Have you ever had rheumatic fever? If yes, when? _________________________________

YES / NO Are you aware of any heart murmurs? ____

YES / NO Do you have high or low blood pressure? ______________________________________

YES / NO Do you have any artificial joints or prosthesis? __________________________________

YES / NO Have you ever had a serious illness or major surgery? If so, explain: __________________

YES / NO Have you ever had radiation or chemo treatment for a tumor, growth or other condition? ____________

YES / NO Have you ever taken Fosamax, Zometa, Aredia or any other oral or intravenous bone loss therapy (bisphosphonates)? __________

YES / NO Have you been treated for bone tumors, excessive calcium in your blood, or osteoporosis? ____________

YES / NO Do you have inflammatory diseases such as arthritis or rheumatism? ____________________

YES / NO Do you have any blood disorders, such as anemia, leukemia, sickle cell, etc.? ______________

YES / NO Have you ever bled excessively after being cut or injured? __________________________

YES / NO Do you have any stomach, kidney, liver, or other organ problems? ____________________

YES / NO Are you diabetic? ____

YES / NO Do you have fainting or dizzy spells? ____

YES / NO Do you have asthma? ____

YES / NO Do you have epilepsy or seizure disorders? ____________________________________

YES / NO Have you tested HIV positive? ____

YES / NO Do you have AIDS? ____

YES / NO Have you had or do you test positive for hepatitis? ________________________________

YES / NO Do you or have you had T.B.? ____

YES / NO Do you smoke, chew, use snuff or any other forms of tobacco? ________________________

YES / NO Do you consume more than one or two alcoholic beverages a day? ____________________

YES / NO Do you use any controlled substances? ____

YES / NO Have you had psychiatric treatment? ____

YES / NO Have you taken fenfluramine, fenfluramine with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products?

YES / NO Do you have any disease condition or problem not listed? If so, explain: _______________

YES / NO Is there anything else we should know about your health that we haven't covered in the form? ____________

YES / NO Would you like to speak to the Doctor privately about any problem? ____________________

I CERTIFY THAT THE ABOVE INFORMATIUON IS COMPLETE AND ACCURATE.

PATIENT'S/GUARDIAN'S SIGNATURE: ______________________________________ DATE: ________________