Complete Health Dental History(Copy)

Patient Name: Birth Date: Date Created:

Although dentist primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have a

Do we have permission to confirm your appointments with our automated system? ◯ Yes ◯ No

When was your last medical exam? ____

When was your last dental exam? ____

Have you ever taken a bisphosphonate medication (Fosamax, Actonel, etc)? ◯ Yes ◯ No

Do you require a premedication (antibiotics) prior to dental treatment? ◯ Yes ◯ No

List medications you are currently taking: ____ Comment ____

Are you allergic to any of the following:

Aspirin	◯ Yes ◯ No	Penicillin	◯ Yes ◯ No	Clindamycin	◯ Yes ◯ No
Latex	◯ Yes ◯ No	Codeine	◯ Yes ◯ No	Anesthetics	◯ Yes ◯ No

Any other Allergies? ◯ Yes ◯ No If yes ____

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

Arthritis/ Gout/ Rheumatism	◯ Yes ◯ No	Anemia	◯ Yes ◯ No	Aids/ HIV positive	◯ Yes ◯ No
Artificial Joint/ pins	◯ Yes ◯ No	Asthma/ Lung Condition	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Epilepsy/ Seizures	◯ Yes ◯ No
Heart Attack/ Stroke	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Dementia/ Alzheimer's	◯ Yes ◯ No
Heart Disease	◯ Yes ◯ No	Headaches/ migraines	◯ Yes ◯ No	Herpes / Fever Blisters/ shingles	◯ Yes ◯ No
Cancer/ chemo/ radiation	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No	Pacemaker/ Artificial Valve	◯ Yes ◯ No
High Blood Pressure	◯ Yes ◯ No	Hemophilia/ Blood Disorder	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No
Osteoporosis	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Pain in Jaw joints	◯ Yes ◯ No
Tumors/ Growths	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Chronic Inflammation	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Stomach/ Intestinal Disease	◯ Yes ◯ No

Any other serious illness? ◯ Yes ◯ No If yes ____

Have you had any major surgeries? ◯ Yes ◯ No If yes ____

What is your visit for today? ____ Comment ____

Are you happy with your smile? ◯ 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 re

Signature of Patient, Parent or Guardian:

X____________________________________ Date:__________