kneeland dental care

Health History Form

Patient Name: First _____ MI ____ Last _____Date of Birth _____

Have you had, or do you have any of the following? (Check all that apply)

- ☐ Heart disease
- ☐ Heart attack
- ☐ Heart defects
- ☐ Heart murmur
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ High blood pressure
- ☐ Stroke
- ☐ Anemia
- ☐ Blood disease
- ☐ Asthma
- ☐ Emphysema or COPD
- ☐ Other respiratory disease
- ☐ Tuberculosis
- ☐ Sinus problems
- ☐ Diabetes
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Reflux/GERD
- ☐ Stomach problems
- ☐ Kidney disease
- ☐ Liver Disease
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Sexually transmitted disease
- ☐ Herpes
- ☐ AIDS/HIV
- ☐ Seizures/Epilepsy
- ☐ Arthritis
- ☐ Steroid therapy within the last 2 years
- ☐ Osteoporosis
- ☐ Bisphosphonate therapy
- ☐ Artificial joints: Date of Surgery _____
- ☐ Anxiety
- ☐ Depression
- ☐ Glaucoma
- ☐ Headaches
- ☐ Dizziness
- ☐ Tumor or Cancer
- ☐ Chemotherapy
- ☐ Radiation therapy
- ☐ Transplants
- ☐ Surgeries: Type _____

Women only (Please circle Yes or No for each)

Yes / No Are you or could you be pregnant? If Yes, how far along? _____
Yes / No Are you nursing?
Yes / No Are you taking birth control pills?

Are you allergic or have you reacted adversely to any of the following?

- ☐ Local anesthetics: Please list_____
- ☐ Penicillin
- ☐ Other antibiotics: Please list _____
- ☐ Sulfa Drugs
- ☐ Aspirin
- ☐ Acetaminophen (Tylenol)
- ☐ Ibuprofen (Advil, Motrin)
- ☐ Codeine
- ☐ Other pain reliever or narcotic: _____
- ☐ Metals
- ☐ Latex
- ☐ Seasonal
- ☐ Food
- ☐ Other: _____

All Patients (Please circle Yes or No for each)

Yes / No Do you have, or have you ever had any other medical condition or disease NOT listed above?
If Yes, please explain: _____
Yes / No Do you drink alcohol?
If Yes, how often? _____ # drinks per week
Yes / No Do you smoke?
If Yes, how often? _____ # packs per week How long? _____ # of years

Have you been in the hospital, emergency room, or had a serious illness in the last three years? If Yes, please explain
_____

Please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment: _____

Please list all medications, supplements, and/or vitamins that you are currently taking: _____
_____

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature _____ Date _____

Physician's Name _____ Phone Number _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____ _____ _____

Patient's Signature (Parent or guardian, if minor) Date Dentist's Signature Date

_____

Print name