West Portal Family Dentistry

Patient Name : ______________________________ Phone #: (______) - _______ - _______

Emergency Contact Name : ______________________________ Phone #: (______) - _______ - _______

Physician Name: ________________ Hospital or HMO # ____________ Phone #: (______) - _______ - _______

HEALTH HISTORY

1. Has there been any changes in your health in the past two years? ☐ Yes ☐ No
2. Date of last medical examination: ______/______/______
3. Are you under physician's care now? ☐ Yes ☐ No
4. Have you ever been hospitalized or had a serious illness? ☐ Yes ☐ No
5. Are you taking any meditations or drugs including over the counter medicines or oral contraceptives? ☐ Yes ☐ No

   If Yes, Please List: ______________________________

6. Have you ever taken diet drugs Fen-Phen or Redux? ☐ Yes ☐ No
7. Do you take anticoagulant or blood thinner medicine? ☐ Yes ☐ No
8. Are you using any recreational drugs or tobacco? ☐ Yes ☐ No

(For Women)-

9. Are you pregnant? *If Yes, Months:* __________ ☐ Yes ☐ No

   Any complications with past pregnancies?______________________________

   Are you nursing at present? ☐ Yes ☐ No

Do you have now or have you ever had any of the following?

10. Heart disease, pacemaker, irregular heartbeat, or endocarditis. ☐ Yes ☐ No
11. Shortness of breath with limited activity or when lying down. ☐ Yes ☐ No
12. Chest pains or angina pectoris or heart attack. ☐ Yes ☐ No
13. Rheumatic fever or rheumatic heart disease. ☐ Yes ☐ No
14. Heart murmur, mitral valve prolapse, or heart defect from birth. ☐ Yes ☐ No
15. Strokes, severe headaches, numbness, or tingling sensations. ☐ Yes ☐ No
16. High blood pressure or low blood pressure. ☐ Yes ☐ No
17. Fainting spells, convulsions, or epilepsy. ☐ Yes ☐ No
18. Nervous breakdown, emotional problems, anxiety, or depressive disorder. ☐ Yes ☐ No
19. Lung disease (T.B., asthma, emphysema, bronchitis, or other breathing problems). ☐ Yes ☐ No
20. Liver disease (hepatitis, jaundice, cirrhosis or problem with drinking. ☐ Yes ☐ No
21. Kidney disease, dialysis, or transplant. ☐ Yes ☐ No

22. Prolonged bleeding following injuries, surgeries, or transfusion? ☐ Yes ☐ No

23. Diabetes? ☐ Yes ☐ No

24. Any diet or activity limitation? ☐ Yes ☐ No

25. Venereal disease (syphilis, gonorrhea, herpes, warts, other)? ☐ Yes ☐ No

If Other, Explain:____

26. Blood disorder (anemia, leukemia, or other) ☐ Yes ☐ No

27. Thyroid diseases? ☐ Yes ☐ No

28. Thrombophlebitis? ☐ Yes ☐ No

29. Cancer or cancer treatment (radiation, surgery, or chemotherapy)? ☐ Yes ☐ No

30. AIDS or immunosuppressive disorders? ☐ Yes ☐ No

31. Ulcers, stomach or intestinal disease? ☐ Yes ☐ No

32. An unusual reaction to any dental treatment? ☐ Yes ☐ No

Explain:____

33. Arthritis, rheumatism, painful swollen joints, osteoporosis. ☐ Yes ☐ No

34. Artificial implants – hips or others. ☐ Yes ☐ No

35. Any visual disorder (glaucoma or other), ☐ Yes ☐ No

36. Any hearing impairment. ☐ Yes ☐ No

Have you become sick from, shown any allergy to or have been told not to take the following meditations:

37. Novacaine, xylocaine, or other anesthetics. ☐ Yes ☐ No

38. Penicillin, or other antibiotics. ☐ Yes ☐ No

39. Aspirin, codeine, Demerol, Valium, barbiturates, or other pain medications. ☐ Yes ☐ No

40. Other medications or allergies, hay fever, hives, skin rash, allergy to latex. ☐ Yes ☐ No

41. Is there anything of importance in your medical history that has not been asked? ☐ Yes ☐ No

Explain:____

ARE YOU OR HAVE YOU EVER TAKEN BISPHOSPHONATE DRUGS? Yes ☐ No

Doctor's Notes and Summery:

____

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____ ____/____/____

Patient, Parent or Legal Guardian's Signature ***Date***

____ ____/____/____

Doctor's Signature ***Date***