



## Patient Health Information

Your oral health is a crucial part of your overall well-being. General health issues and medications you take can significantly impact the dental care we provide. Please answer the following questions as accurately as possible!

**Are you under a physician's care for anything other than routine physicals/check-ups?**  Yes  No

If yes, what for? \_\_\_\_\_

**Have you been hospitalized or had a major operation in the last 3 years?**  Yes  No

If yes, for what reason? \_\_\_\_\_

**Have you ever been told to take Antibiotic Premedication prior to dental work?**  Yes  No

If yes, for what reason? \_\_\_\_\_

**Have you ever taken Bisphosphonates (bone density medication for osteoporosis)?**  Yes  No

**Are you taking any prescription medications or supplements?**  Yes  No

If yes, list names and dosages below:

**Have you ever had or do you currently have any of the following?**  No  Yes (check items below)

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| <input type="checkbox"/> Allergy – Anesthetic<br><input type="checkbox"/> Allergy – Acrylic<br><input type="checkbox"/> Allergy – Codeine<br><input type="checkbox"/> Allergy – Penicillin<br><input type="checkbox"/> Allergy – Sulfa Drugs<br><input type="checkbox"/> Allergy – Latex<br><input type="checkbox"/> Allergy – Metal<br><input type="checkbox"/> Allergy (Other): _____<br><input type="checkbox"/> Anaphylaxis<br><input type="checkbox"/> Alcohol Abuse<br><input type="checkbox"/> Anemia<br><input type="checkbox"/> Arthritis/Gout<br><input type="checkbox"/> Artificial Joint(s)<br><input type="checkbox"/> Asthma<br><input type="checkbox"/> Bisphosphonate Use/Osteoporosis<br><input type="checkbox"/> Blood Thinners<br><input type="checkbox"/> Cancer<br><input type="checkbox"/> Chemotherapy<br><input type="checkbox"/> Chest Pain/Angina | <input type="checkbox"/> Cigarette Smoking/Vaping<br><input type="checkbox"/> Dry Mouth<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Drug Addiction<br><input type="checkbox"/> Epilepsy/Seizures<br><input type="checkbox"/> Fainting/Dizziness<br><input type="checkbox"/> Frequent Headaches/Migraines<br><input type="checkbox"/> Glaucoma<br><input type="checkbox"/> High Cholesterol<br><input type="checkbox"/> Heart Attack/Failure<br><input type="checkbox"/> Heart Disease<br><input type="checkbox"/> Heart Murmur<br><input type="checkbox"/> Heart Valve Replacement<br><input type="checkbox"/> Hepatitis B<br><input type="checkbox"/> Hepatitis C<br><input type="checkbox"/> HIV<br><input type="checkbox"/> Hypoglycemia (Low Blood Sugar)<br><input type="checkbox"/> High Blood Pressure<br><input type="checkbox"/> Kidney Disease<br><input type="checkbox"/> Liver Disease<br><input type="checkbox"/> Memory Issues (Alzheimer's) | <input type="checkbox"/> Mitral Valve Prolapse<br><input type="checkbox"/> Nervous Disorders (Anxiety)<br><input type="checkbox"/> Pacemakers<br><input type="checkbox"/> Pain in Jaw Joints (TMJ)<br><input type="checkbox"/> Parkinson's<br><input type="checkbox"/> Psychiatric Care<br><input type="checkbox"/> Radiation Treatment<br><input type="checkbox"/> Respiratory Problems<br><input type="checkbox"/> Rheumatic Fever<br><input type="checkbox"/> Shingles<br><input type="checkbox"/> Sinus Problems<br><input type="checkbox"/> Sleep Disorders/Sleep Apnea<br><input type="checkbox"/> Smokeless tobacco use<br><input type="checkbox"/> Stomach Problems<br><input type="checkbox"/> Stroke<br><input type="checkbox"/> Thyroid Disease<br><input type="checkbox"/> Tuberculosis<br><input type="checkbox"/> Ulcers<br><input type="checkbox"/> Other Illness not listed?<br>Describe: _____<br>_____ |
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**Women only:**

Pregnant or trying to get pregnant?  Yes  No      Nursing?  Yes  No

To the best of my knowledge, I have answered all questions on this form accurately. I understand that providing incorrect information can be harmful to my (or the patient's) health. I will inform the dental office of any changes in my medical status.

**Signature of Patient/Guardian:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Doctor Review:** \_\_\_\_\_

**Date:** \_\_\_\_\_