NEW PATIENT HEALTH HISTORY FORM
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Name_____Date_____Age_____

Date of birth_____Social Security #_____

Address_____Town_____Zip_____

Referring Dentist & Number_____ Date of last visit_____

Physician & Number_____ Date of last visit_____

Please respond by circling YES or NO to the questions that follow:

1. Have you ever had hives after taking medication NO YES
2. Are you allergic to any medication that you know of NO YES
3. Does any medication make you physically ill, nauseated, sick NO YES
4. Have you ever had hepatitis (A,B,C other) NO YES
5. Have you ever been denied permission to give blood as a donor NO YES
6. Have you had any recent extended hospital stays NO YES
7. Have you been told you have a heart murmur NO YES
8. Have you been told you needed to take antibiotics for dental visits Because of the murmur NO YES
9. Have you had a stroke or CVA NO YES
10. Have you ever had Rheumatic Fever NO YES
11. Have you been diagnosed with high or low blood pressure(circle which( NO YES
12. Have you been diagnosed as being anemic NO YES
13. Have you ever had tuberculosis or lived with anyone who did NO YES
14. Have you ever been diagnosed as epileptic or experienced seizures NO YES
15. Are you prone to fainting NO YES
16. Do you have any sexually transmitted diseases NO YES
17. Do you have AIDS suspect you have AIDS or are HIV+ NO YES
18. Have you had radiation therapy for a disease NO YES
19. Do you ever have cold sores or fever blisters on your lips NO YES
20. Do you ever have apthous ulcers (cankor sores) in your mouth NO YES
21. Do you have nose bleeds often or have you been diagnosed with a Bleeding disorder NO YES
22. Are you ever short of breath climbing a flight of stairs NO YES
23. Do you get chest pain or experience angina after mild exercise NO YES
24. Do you feel you suffer from palpitations or fast heart beat NO YES

25. Are you taking or have you taken any medication regularly in the Past 3 weeks. NO YES
26. What is the medication(s)_____
27. Have you had any injections in the last 6 months NO YES
28. Have you had to have cortisone treatments in the last year NO YES
29. Are you troubled by nervousness, tension or emotional problems NO YES
30. Have you been diagnosed with diabetes, and if so which type NIDDM or IDDM NO YES
31. Are you asthmatic or suffer from hay fever (circle one) NO YES
32. Do you take aspirin every day or every other day NO YES
33. Do you smoke presently and if so how much in terms of pack per day NO YES
34. Did you smoke, how much_____ and when did you quit_____ NO YES
35. Have you been diagnosed with thyroid problems NO YES
36. Have you been seen by a physician in the last year NO YES
37. Have you had a MI, myocardial infection, heart attack within the last 6 months NO YES
38. Are you being treated for osteoporosis. What medication_____

FOR WOMEN ONLY

39. Are you taking oral contraceptives NO YES
40. Are you pregnant NO YES
41. Have you had any significant bleeding associated w/menses NO YES

FOR ALL

Please state any other aspect of your medical history that you feel is important, including history, medication, timing, or complexity as it might pertain to periodontal/dental/surgical therapy

_____

_____

For CONVERSATION

How many children do you have _____ what ages_____
What is your occupation_____

FOR CHILDREN ONLY

I authorize examination and treatment of my child _____(print child's name, age, date of birth)

Date_____ Signature of Parent or Guardian_____

Date_____ Your Signature_____

FILL OUT AND PLEASE BRING WITH YOU TO INITIAL CONSULTATION

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Date:

Patient's Name:_____

Street:_____

Town:_____ Zip Code:_____

Phone:_____ Cell:_____ Work:_____

Referring Dentist:_____Phone:_____

Physician:_____Phone:_____

Reason for dentists referral:_____

Any Discomfort/Pain:_____Any previous Perio Tx:_____

Are there recent X-Rays available? Y N

Have you requested them from the Dentist for review? Y N Date Requested:_____

Will you bring them to the initial exam? Y N

Do you need antibiotic premedication? Y N

Is that on physician recommendation for:

A) Previous Endocarditis B) Renal Dialysis C) Prosthetic Joints (Hips,toes,etc)
D) Scarlet/Rheumatic Fever E) Significant heart problems (heart murmer,mitral valve prolapse,prosthetic valve).

Are you allergic to any antibiotics? Penicillin: Y N Erythromycin: Y N Other:_____

What pharmacy do you use:_____Phone:_____

Dental Insurance Provided Name and Address:

_____

Id #:_____ Group #:_____

Employer Name:_____ D.OB.:_____

PLEASE BRING WITH YOU TO THE INITIAL CONSULTATION