

LALOR CREEKSIDE DENTAL HEALTH HISTORY

Patient Full Name: _____ **Date:** _____

HEALTH HISTORY

Are you currently under the care of a physician? Yes No
 If yes, Physician's Name: _____ Physician's Phone #: _____

Have you ever been hospitalized or had a major operation? Yes No
 If yes, what for: _____

Have you ever had a serious head or neck injury? Yes No
 If yes, explain: _____

Are you taking any medications, pills, or drugs? Yes No
 If yes, list: _____

Do you take, or have you taken Phen-Fen or Redux? Yes No

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Do you use controlled substances? Yes No

WOMEN

Are you pregnant/trying to get pregnant? Yes No

Are you nursing? Yes No

Are you taking oral contraceptives? Yes No

ALLERGIES

Are you allergic to any of the following? **(Please check all that apply)**

Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex

Other: _____

HEALTH PROBLEMS

Do you currently or have you ever had any of the following? **(Please check all that apply)**

<input type="checkbox"/> AIDS/HIV Positive	<input type="checkbox"/> Cortisone Medicine	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Renal Dialysis
<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Hepatitis B or C	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Anemia	<input type="checkbox"/> Easily Winded	<input type="checkbox"/> Herpes	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Angina	<input type="checkbox"/> Emphysema	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Shingles
<input type="checkbox"/> Arthritis/Gout	<input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> Hives or Rash	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Artificial Join	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Spina Bifida
<input type="checkbox"/> Asthma	<input type="checkbox"/> Fainting Spells/Dizziness	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Stomach/Intestinal Disease
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Frequent Cough	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Stroke
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Frequent Diarrhea	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Swelling of Limbs
<input type="checkbox"/> Breathing Problem	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Genital Herpes	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Galucoma	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Pain in Jaw Joints	<input type="checkbox"/> Tumors or Growths
<input type="checkbox"/> Chest Pains	<input type="checkbox"/> Heart Attack/Failure	<input type="checkbox"/> Parathyroid Disease	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Cold Sores/Fever Blisters	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Congenital Heart Disorder	<input type="checkbox"/> Heart Pace Maker	<input type="checkbox"/> Radiation Treatments	<input type="checkbox"/> Yellow Jaundice
<input type="checkbox"/> Convulsions	<input type="checkbox"/> Heart Trouble/Disease	<input type="checkbox"/> Recent Weight Loss	

Have you ever had any serious illness not listed above? Yes No
 If yes, explain: _____

Are you required to take an antibiotic pre-medication for dental procedures due to an existing condition? Yes No
 If yes, which medication do you usually take: _____