HERRICKDENTAL

Patient Name_____

Health History

Are you currently under a physician's care? ☐ Yes ☐ No If yes, please explain _____

Have you recently been hospitalized? ☐ Yes ☐ No If yes, please explain_____

Are you taking any medications? ☐ Yes ☐ No If yes, please list_____

Do you take Aspirin, Coumadin, or Plavix? ☐ Yes ☐ No

Have you ever taken Fosamax, Boniva, Actenol or any other medications containing bisphosphonates? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

Women Only

Are you:
Pregnant ☐ Yes ☐ No
Nursing ☐ Yes ☐ No
Taking Oral Contraceptives ☐ Yes ☐ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Local Anesthetics ☐ Codeine
☐ Acrylic ☐ Metal ☐ Sulfa Drugs
☐ Other If yes, please explain_____

Medical History

Do you or have you had any of the following?

Yes ☐ No ☐ Tuberculosis *Active? Y N*
Yes ☐ No ☐ Emphysema
Yes ☐ No ☐ Cardiovascular Disease
Yes ☐ No ☐ Sinus Trouble
Yes ☐ No ☐ Angina
Yes ☐ No ☐ Artificial Heart Valve
Yes ☐ No ☐ Congestive Heart Failure
Yes ☐ No ☐ Cancer
Yes ☐ No ☐ Arthritis
Yes ☐ No ☐ Diabetes-Type I or Type II
Yes ☐ No ☐ Artificial Joint
Yes ☐ No ☐ Ulcers

Yes ☐ No ☐ Heart Attack
Yes ☐ No ☐ Thyroid Problems
Yes ☐ No ☐ Heart Murmur
Yes ☐ No ☐ Stroke
Yes ☐ No ☐ Asthma
Yes ☐ No ☐ Hepatitis
Yes ☐ No ☐ Low Blood Pressure
Yes ☐ No ☐ Epilepsy
Yes ☐ No ☐ High Blood Pressure
Yes ☐ No ☐ Seizures
Yes ☐ No ☐ Congenital Heart Disorder
Yes ☐ No ☐ Mental Health Disorders

Yes ☐ No ☐ Mitral Valve Prolapse
Yes ☐ No ☐ Kidney Problems
Yes ☐ No ☐ Pacemaker
Yes ☐ No ☐ Osteoporosis
Yes ☐ No ☐ Rheumatic Fever
Yes ☐ No ☐ Headaches/Migraines
Yes ☐ No ☐ Anemia
Yes ☐ No ☐ Glaucoma
Yes ☐ No ☐ Hemophilia
Yes ☐ No ☐ STD's
Yes ☐ No ☐ HIV/AIDS
Yes ☐ No ☐ Shingles

Dental History

Yes ☐ No ☐ Are you happy with your smile?
Yes ☐ No ☐ Are you experiencing pain or discomfort?
Yes ☐ No ☐ Do your gums bleed when you brush or floss?
Yes ☐ No ☐ Do you have any clicking, popping, or discomfort in the jaw?
Yes ☐ No ☐ Do you grind your teeth?
Yes ☐ No ☐ Do you have sores or ulcers in your mouth?
Yes ☐ No ☐ Do you have earaches or neck pain?
Yes ☐ No ☐ Have you had orthodontic (braces) treatment?
Yes ☐ No ☐ Have you had any problems with previous dental treatments?
Yes ☐ No ☐ Have you had periodontal (gum) treatments?
Yes ☐ No ☐ Do you wear dentures or partials?
Yes ☐ No ☐ Does food or floss catch between your teeth?
Yes ☐ No ☐ Are your teeth sensitive to hot, cold, sweets, or pressure?
Yes ☐ No ☐ Has a previous physician or dentist recommended that you take antibiotics prior to your dental treatment?
Yes ☐ No ☐ Do you or has a doctor prescribed you to use a CPAP machine?

Any additional information you would like us to know:

I understand that the information I have given today is correct to the best of my knowledge. I also understand this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status.

_____
Signature of Patient, Parent or Guardian