1

Health Information and History

Detient/o Nemo			Today's Date: _		
Patient's Name: If you are completing this form for anotyour name: Your name:	ther person:				
Emergency Contact: (If not listed abo	ove)				
Name:		Pnone:	Relationship:		
Primary Physician: Date of last physical examination:					
, ,		_ Date of last blood te	30 WORK up.		
Other Physicians & Specialists Name:	Specialty:	Phone:	City & Sta	te·	
Name:					
1. With in the last 3 years, have If Yes, please give reasons and da	you been hospita	lized or had surge	ery?	□ Yes —	
2. Have you ever been instructed take ANY special precautions of Yes, please explain:	before any denta	al appointments*?		□ Yes	□ No
3. Are you taking ANY drugs, mo (If you brought a complete written list was prescribed: Over-the-counter (OTC) medication	vith you, give that to th	e receptionist instead)		□ Yes	⊔ No
Vitamins, natural or herbal prepara	·				
Are you having or have you ever ha		1 3		□ Yes	□ No
4. Are you taking or have you eve	r taken / been treat	ted with a Bisphos	phonate (Fosamax)	? □ Yes	□ No
5. Are you allergic to or have yo LatexMetals orFluorideNitrous ox	jewelry	ed an unusual rea Dental and General ar	esthesia (local)		
6. Are you allergic to or have yoPenicillin (or related drugs)Aspirin / Ibuprofen (Advil, Motrin, NNSAID (Celebrex, Vioxx, Anaprox)	Tranqı Nuprin) Keflex	uilizers (Valium) « (Cephalexin)	Tetra cycline Sulfa drugs		deine ne
7. Have you had an allergic reac ANY other medications, drug- If Yes, please list:	s, pills, or treatme	ents?		☐ Yes	□ No
Continued on next page			Reviewed By:		

 $\textbf{Copyright} @ \textbf{LED Dental Inc.} ~ \tiny \texttt{(04-30-07)}$

Health Information and History (continued)

Patient's Name:							
8. Do you have, or have you ever had	d, any Yes		e following? (Please check Yes or No for each ques	stion) Yes	Nο		
Congenital heart defects	103	110	Asthma	103	110		
Angina or chest pains			Hay fever, skin or food allergies				
Atherosclerosis			or allergies in general				
Congestive heart failure			Sinus problems				
Coronary artery disease			Tuberculosis, emphysema or lung disorder				
Heart surgery			Skin problems				
If Yes, type & date			A sore or wound that bleeds easily or does not heal				
If Yes, date			A thyroid problem or disease				
Rheumatic heart disease / rheumatic fever			Arthritis				
Infective Endocarditis*			Glaucoma or any eye diseases				
Heart valve(s) damage / Mitral valve prolapse			Epilepsy or other seizure disorder				
Artificial heart valve			Any kidney problems				
Pacemaker			Ulcers, acid reflux, or stomach problems				
Stroke or CVA			A compromised immune system				
High blood pressure			(Lupus, HIV, AIDS, radiation immune problem, etc.)				
Low blood pressure			An active sexually transmitted disease (STD)				
Anemia			Any mental health issues				
Hemophilia or bleeding disorder			Been treated for any psychiatric condition				
Excessive bleeding from any cut or incident			Women Only	Yes	No		
Diabetes or blood sugar problems			Women Only:	162	IVO		
Any artificial joint, joint surgery, or prosthesis			Are you pregnant If Yes, what is your due date:				
If Yes, what join t or area:			Do you think you might be pregnant	_			
When was operation done:			Are you presently nursing				
Hepatitis, jaundice, or other liver problems			Are you using birth control medication				
Any form of cancer			Are you taking hormone replacement therapy				
An organ transplant			Are you taking normone replacement therapy				
information that you would like us	to kno	ow ab	r medical problems, or is there ANY other out, or that we should be made aware of? □				
will be informed of the changes without fail. I also consent information released to aid in care and treatment. I also he for the above named individual until further notice.	to allow tereby con	this practisent to a	n is correct and if there is ever any change in health, or medications, tice to contact any healthcare provider(s) and to have the patient's h allow diagnosis, proper health care and treatment to be performed by	ealth			
I understand there are no guarantees or warranties in hea	Ith or den	ital care.					
Signature			Date				
(Parent or guar	rdian, if p	oatient	is a minor)				
			Reviewed By:				