Sandston Comprehensive Dentistry

PATIENT HEALTH HISTORY UPDATE

Patient Name: _____ **Date of Birth:** ____/____/____

Emergency contact and relationship: _____ **Phone:( )** _____

Primary care physician or facility: _____ **Date of last visit**_____

Have there been any major changes in your health in the past year? (***major illness, hospitalization, injury, surgery etc.***)

_____

_____

PLEASE MARK BELOW IF ANY OF THE FOLLOWING MEDICAL CONDITIONS APPLY TO YOU:

- ○ Anemia
- ○ Arthritis: osteo / rheumatoid
- ○ Blood disease / bleeding disorder_____
- ○ Cancer *please explain* _____
  _____
- ○ Circulatory problems
- ○ Cortisone injections/ steroid therapy
- ○ Diabetes Are you on insulin? Y/ N
  Last A1C level?_____
- ○ Frequent headaches or migraines
- ○ Gastrointestinal problem (including reflux) _____
- ○ Cardiovascular condition (hypertension, heart attack, etc) *Please explain*_____
  _____
  Cardiologist name_____
- ○ Hepatitis: Type_____
- ○ HIV
- ○ Immune/ Autoimmune Disorder _____
- ○ Jaw pain or clenching/ grinding teeth
- ○ Joint Replacement: *Area(s) and date*_____
  _____
  _____
  Orthopedic surgeon name_____
  Do you take antibiotic premedication prior to dental visits? Y / N
- ○ Kidney problems
- ○ Liver problems
- ○ Psychiatric care
- ○ Pulmonary disease (including asthma)_____
- ○ Sleep disorder
  CPAP machine? Y / N Snoring? Y / N
- ○ Stroke date_____
- ○ Thyroid problems
- ○ Tuberculosis
- ○ Dry mouth
- ○ Personal or family history of periodontal disease
- ○ Pregnant or nursing
- ○ Smoking: amount _____
- ○ Tobacco use ("dip", etc) how long?_____
- ○ Alcohol use Daily / Weekly / Socially

PLEASE INFORM US if you have any diagnosis or condition, including surgeries, not listed above.

_____

_____

_____

Have you had problems associated with previous dental treatment? *Please explain*_____

_____

PLEASE SEE REVERSE

Sandston Comprehensive Dentistry

MEDICATIONS:

_____ _____ _____

_____ _____ _____

_____ _____

_____ _____ _____ _____

- NONE

PROCEDURES ROUTINELY PERFORMED IN DENTISTRY MAY INTERACT WITH PRESCRIPTION MEDICATIONS AND A NUMBER OF SUPPLEMENTS.**Please check**any below that apply to you.

- Benzodiazepines (Ex:Ativan, Valium, Xanax, clonazepam)Other_____
- "Blood Thinners" (Ex: Coumadin, Eliquis, Plavix, Pradaxa, Xarelto) Other_____
  Date started: _____
- Daily aspirin regimen
- Bone density medications (Ex: Actonel, Boniva, Fosamax, Prolia, Reclast) Other _____
  Date started and/or stopped_____
- Herbal or homeopathic supplements_____

ALLERGIES **Please list any other drug allergies:**

- Latex _____ _____
- Local Anesthetic("Novocaine",etc) _____ _____
- Penicillin**or other antibiotic** (*please list*) _____ _____
- Codeine _____ _____
- NONE

Pharmacy name and number: _____

To the best of my knowledge, the above information is complete and accurate. I understand it is my responsibility to inform the doctor if I, or my minor child, have a change in medical information.

Signature of Patient or Guardian: _____

Date: _____

OFFICE USE ONLY:_____

_____

_____

_____

_____

Reviewed by _____