Patient History Form

Name of dental office_____Date of planned procedure_____

Name_____ Home Phone_____
Last First Middle

Patient's Date of Birth____/_____/_____ Sex: M ☐ F ☐ Height____ Weight _____ (lbs/Kg)

Address_____cell Phone (_____)_____

City_____ State_____ Zip Code_____ Contact's email_____

Parent/ Guarantor's Name _____ DOB___/___/____ SS#_____

Subscriber to Insurance **Y** ☐ / **N** ☐ **(IF NO or HAVE SECONDARY INSURANCE): please fill in next line**

Insured's Name_____ Relationship _____DOB___/___/_____ SS#_____

Name of the patient's Physician _____ Phone No. (____)_____Last Exam__/___/___

If state DSHS insurance: WA# _____

List all medications the patient is taking (include vitamins, laxatives, and antibiotics):

_____

_____

Does the patient have any allergies? Y ☐ /N ☐

Drugs_____

Foods_____

Other_____

1. Is the patient in good health?…… Yes☐ No☐
2. Has there been any change in his/her general health within the last year?…… Yes☐ No☐
3. Is the patient now under the care of a physician?…… Yes☐ No☐
   If so, what is the condition being treated?_____
4. Has the patient had any serious illness, operation, or been hospitalized in the past 5 yrs? …Yes☐ No☐
   If so, what was the illness or problem?_____ Yes☐ No☐
5. Is the patient taking any medicine(s) including non-prescription medicine?……... Yes☐ No☐
   If so, what medicine(s) are you taking?_____
6. Does the patient have or has the patient had any of the following diseases or problems?…….. Yes☐ No☐
   a) Damaged heart valves or artificial heart valves, including heart murmur or Rheumatic heart disease? …… Yes☐ No☐
   b) Knee or hip replacement, plastic or artificial arteries?…… Yes☐ No☐
   c) Congenital heart defect or murmur? …… Yes☐ No☐
   d) Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, High blood pressure, arteriosclerosis, stroke)?……..…… Yes☐ No☐
      1. Do he/she have chest pain upon exertion?…… Yes☐ No☐
      2. Is he/she ever short of breath after mild exercise or when lying down?…… Yes☐ No☐
      3. Does the patient have inborn heart defects?…… Yes☐ No☐
      4. Does the patient have a cardiac pacemaker?……...Yes☐ No☐
      5. Does the patient have an arrhythmia or an irregular heart beat?……Yes☐ No☐
   e) Has the patient's physician ever instructed him/her to take antibiotics prior to dental therapy for a Medical condition?
      If yes, why?_____ Yes☐ No☐
7. Does the patient have/ had any of the following diseases or problems?……..…… Yes☐ No☐
   a) Respiratory disease……..…. Yes☐ No☐
      1. Asthma, Bronchitis, Pneumonia, Emphysema, Tuberculosis (TB)……..…. Yes ☐ No☐
         how often is inhaler needed/used? _____
      2. Sleep Apnea or loud snoring……. Yes ☐ No ☐
      3. Hayfever, sinus trouble, allergies…… Yes☐ No☐
      4. Does the patient currently have a cold or flu?…….. Yes☐ No☐

PLEASE TURN OVER

b) Diabetes …… Yes ☐ No ☐
c) Persistent diarrhea or recent weight loss …….. Yes ☐ No ☐
d) Hepatitis, jaundice or liver disease …….. Yes ☐ No ☐
e) AIDS or HIV …… Yes ☐ No ☐
f) Fainting spells or seizures …… Yes ☐ No ☐
g) Thyroid problems …… Yes ☐ No ☐
h) Arthritis or painful swollen joints …… Yes ☐ No ☐
i) Stomach ulcer or hyperacidity …… Yes ☐ No ☐
j) Kidney trouble …… Yes ☐ No ☐
k) Persistent swollen glands in neck …… Yes ☐ No ☐
l) Low blood pressure …… Yes ☐ No ☐
m) Epilepsy or other neurological disease …… Yes ☐ No ☐
n) Problems with mental health …… Yes ☐ No ☐
o) Cancer …….. Yes ☐ No ☐
p) Problems of the immune system …….. Yes ☐ No ☐

8. Does the patient bleed easily, bruise easily or have you had abnormal bleeding with previous treatment? ……..Yes ☐ No ☐
9. Does the patient have any blood disorder such as anemia? …….. Yes ☐ No ☐
10. Has the patient had surgery or x-ray treatment for a tumor, growth of your head or neck? ….. Yes ☐ No ☐
11. Is the patient allergic or has he/she reacted adversely to :…… Yes ☐ No ☐

Local anesthetics	Sedatives	Aspirin	Penicillin or
General	Valium	Advil	other Antibiotics
anesthetic ☐	Demerol ☐	Ibuprofen ☐	Other
Sulfa Drugs	Codeine	Iodine	
Barbiturates	Sleeping pills	Morphine ☐	

12. Has the patient had any serious trouble associated with any previous dental treatment, surgery or any previous anesthetic? Y☐ NO.☐ so, explain_____

_____

13. Has the patient ever had surgery?..... ..... Yes☐ No☐

please list _____

_____

_____

13. Has anyone in your family had a bad reaction to any anesthetic?……. Yes ☐ No ☐
14. Is the patient wearing contact lenses? …….. Yes ☐ No ☐
15. IS THE PATIENT DIAGNOSED WITH ANY GENETIC ABNORMALITIES OR SYNDROMES (eg. down's syndrome)
If yes, please list and describe _____
_____
16. Does the patient have any mental or psychologic disabilities? (eg. autism, ADHD, develepmental delays, etc)
_____

I understand that withholding any information about the patient's health could seriously jeopardize his/her safety. Therefore. I have reviewed this health history carefully and have answered all questions truthfully to the best of my knowledge.

_____ _____
Signature of patient/ or guardian (if minor) Date