FRANTAL DENTAL CARE

PATIENT HEALTH HISTORY

First Name _____Middle Initial ___ Last Name_____ Preferred Name_____

Social Security # _____ Address _____ City/State/Zip_____

Date of Birth _____Home Phone# _____ Work Phone# _____ Cell#_____

Email _____ Preferred Confirmation: Phone, Cell, Text, Email (Please Circle One)

Referred By _____ Employer _____

Dental Insurance _____Group #_____

Spouse's Name_____ Date of Birth _____Social Security # _____

Spouse's Employer _____ Work Phone # _____

Dental Insurance _____Group # _____

Date of last medical exam: _____What was this exam for?_____

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason:
_____

Are you currently receiving care? No Yes If yes, nature of care: _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____
2. _____
3. _____
4. _____

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Abnormal Bleeding	No	Yes	Joint Replacement	No	Yes
Anemia	No	Yes	Kidney Disease	No	Yes
Arthritis	No	Yes	Latex Sensitivity	No	Yes
Asthma	No	Yes	Liver Disease / Jaundice	No	Yes
Cancer / Previous Biopsies	No	Yes	Psychosis	No	Yes
Diabetes	No	Yes	Recurrent Illnesses	No	Yes
Emphysema / Respiratory Illnesses	No	Yes	Rheumatic Fever	No	Yes
Epilepsy	No	Yes	Slow-Healing Mouth Sores	No	Yes
Fainting Spells	No	Yes	Sore / Enlarged Lymph Nodes	No	Yes
Glaucoma	No	Yes	Stroke	No	Yes
Heart Condition: Arrhythmia / Attack / Disease / Pacemaker / Surgery	No	Yes	Stomach Ulcers	No	Yes
Heart Murmur / Mitral Valve Prolapse	No	Yes	Unintentional Weight Loss / Gain	No	Yes
HIV Positive / Related Symptoms	No	Yes	Venereal Disease	No	Yes
Hepatitis / Any Form	No	Yes	Other Infections / Conditions	No	Yes

Are you required to Pre-Medicate before dental treatment? No Yes

Women: Are you pregnant? No Yes
If no, are you planning a pregnancy in the near future? No Yes
Are you a nursing mother? No Yes
Are you taking birth control pills? No Yes

Abnormal Blood Pressure: (High/Low) Today's BP: _____ No Yes

Are you allergic or have you had a reaction to:

a. Local anesthetics ……... No Yes
b. Penicillin or other antibiotics …… No Yes
c. Aspirin ….……...……... No Yes
d. Codeine, Valium or other sedatives…….… No Yes
e. Other _____

Are you a smoker? No Yes
If so, how much do you smoke per day? _____

Do you have any history of alcohol or drug abuse? No Yes

Do you consume grapefruit juice, grapefruits or grapefruit extract? No Yes

Please list any medications you are currently taking:

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Are you taking Tagamet (Cimetidine)? No Yes If yes, how often? _____

Do you take Antacids? No Yes If yes, how often? _____

Are you taking any herbal supplements/medicines? No Yes If yes, which ones?_____

Diet: Restricted Diet _____
How many meals a day _____
Food Allergies _____
Sugar in your diet: ❑ None ❑ Slight ❑ Moderate ❑ High

In case of emergency contact: _____ Relationship: _____

Phone number: _____ Cell phone number: _____

DOCTOR'S USE ONLY

Significant findings, management considerations, and comments on patient interview.

_____

_____

_____

_____

_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

_____	_____	_____
Clinician (Print Name)	*Clinician Signature*	*Date*
_____	_____	_____
Patient (Print Name)	*Patient Signature*	*Date*

HEALTH HISTORY UPDATED

Signature _____Date _____ Blood Pressure_____

Signature _____Date _____ Blood Pressure_____

Signature _____Date _____ Blood Pressure_____

Signature _____Date _____ Blood Pressure_____

Signature _____Date _____ Blood Pressure_____

Signature _____Date _____ Blood Pressure_____

PLEASE VISIT OUR WEBSITE
frantaldentalcare.com