Stonegate Dental

Restorative, Cosmetic & Implant Dentistry

HEALTH HISTORY

PATIENT

► **Your Name (Patient's Name):** ______________________________ Date of last visit: __________

MEDICAL HISTORY

► **Physician's Name:** ______________________________ Date of last visit: __________

► **Have you ever been diagnosed with or experienced the following conditions?**

Condition	Y	N	Condition	Y	N	Condition	Y	N
AIDS/HIV	☐ Y	☐ N	Glaucoma	☐ Y	☐ N	Shortness of breath	☐ Y	☐ N
Anemia	☐ Y	☐ N	Headaches	☐ Y	☐ N	Sinus trouble	☐ Y	☐ N
Arthritis, Rheumatism	☐ Y	☐ N	Heart murmur	☐ Y	☐ N	Skin rash	☐ Y	☐ N
Artificial heart valves	☐ Y	☐ N	Heart problems	☐ Y	☐ N	Special diet	☐ Y	☐ N
Artificial joints	☐ Y	☐ N	Hepatitis Type ___________	☐ Y	☐ N	Stroke	☐ Y	☐ N
Asthma	☐ Y	☐ N	Herpes	☐ Y	☐ N	Swollen feet or ankles	☐ Y	☐ N
Back problems	☐ Y	☐ N	High blood pressure	☐ Y	☐ N	Swollen neck glands	☐ Y	☐ N
Bleeding abnormally	☐ Y	☐ N	Jaundice	☐ Y	☐ N	Thyroid problems	☐ Y	☐ N
Blood disease	☐ Y	☐ N	Jaw pain	☐ Y	☐ N	Tonsillitis	☐ Y	☐ N
Bone Density Medication	☐ Y	☐ N	Kidney disease	☐ Y	☐ N	Tuberculosis	☐ Y	☐ N
Cancer	☐ Y	☐ N	Liver disease	☐ Y	☐ N	Tumor or growth on head or neck	☐ Y	☐ N
Chemotherapy	☐ Y	☐ N	Low blood pressure	☐ Y	☐ N	Ulcer	☐ Y	☐ N
Cigarette, pipe, or cigar smoking	☐ Y	☐ N	Mitral valve prolapse	☐ Y	☐ N	Venereal disease	☐ Y	☐ N
Circulatory problems	☐ Y	☐ N	Nervous problems	☐ Y	☐ N	Weight loss, unexplained	☐ Y	☐ N
Congenital heart lesions	☐ Y	☐ N	Pacemaker	☐ Y	☐ N	Major surgery? ______________	☐ Y	☐ N
Cortisone treatments	☐ Y	☐ N	Psychiatric care	☐ Y	☐ N	Hospitalized for? ______________	☐ Y	☐ N
Diabetes	☐ Y	☐ N	Radiation treatment	☐ Y	☐ N	Do you wear contact lenses?	☐ Y	☐ N
Emphysema	☐ Y	☐ N	Respiratory disease	☐ Y	☐ N	Take any non-prescribed drugs?	☐ Y	☐ N
Epilepsy	☐ Y	☐ N	Scarlet fever	☐ Y	☐ N	If yes, what and how often? ________________		

► **Do you have any other dental or medical condition(s) that could affect your dental treatment?** If so, please describe below:

____

WOMEN ONLY Pregnant? Due date_________ ☐ Y ☐ N Taking birth control pills? ☐ Y ☐ N Are you nursing? ☐ Y ☐ N

► **Have you ever taken any of the group of drugs collectively referred to as "fen-phen"?"** These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ______ Yes ______ No

► **List <u>all</u> medications you are currently taking and the correlating diagnosis:**

Med:______________________________ Dose:_________ Frequency:_________ For:______________

Med:______________________________ Dose:_________ Frequency:_________ For:______________

Med:______________________________ Dose:_________ Frequency:_________ For:______________

Med:______________________________ Dose:_________ Frequency:_________ For:______________

Pharmacy name: ______________________________ Phone (______) ________________

► **Indicate <u>all</u> of your allergies below:**

☐ Aspirin	☐ Iodine	☐ Penicillin
☐ Barbiturates	☐ Latex	☐ Sulfa
☐ Codeine	☐ Local anesthetic	☐ Other ___________

ACKNOWLEDGEMENT

► **<u>Check ONE</u> and acknowledge with your signature below:**

☐ I have had <u>no change</u> in my dental or medical history since my last visit.

☐ I attest that the dental and medical information above is current, complete, true, and accurate. I accept full responsibility for any information not updated or shared with the doctor.

Patient (or Guardian) Signature:____ **Date:** _______/______/_______

Name (if signing for minor):____

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