DENALI
DENTAL CARE

Health History

Patient Name_____ Date_____

Please check if you have any of the following problems:

AIDS / HIV Positive
Alcoholism / Drug Addiction
Allergies
Describe_____
_____
Anemia
Artificial Heart Valves
Artificial Joints
Asthma / Emphysema
Back Problems
Bacterial Endocarditis
Blood Disease / Excessive Bleeding
Bruise Easliy
Cancer
Chemotherapy
Circulation Problems
Cortisone Treatments
Cough (persistent, up blood)
Diabetes
Epilepsy / Seizures
Fainting / Dizziness
Fever (unexplained)
Food Allergies
Glaucoma
Head or Neck Injuries
Headaches / Migraines
Heart Murmur / Defect
Heart (any problems)
Describe_____
Hemophilia
Herpes / Cold Sores /Fever Blisters
Hepatitis A B C
High Blood Pressure
Jaw Pain
Kidney Disease
Liver Disease
Lung Disease
Mitral Valve Prolapse
Nervousness
Pacemaker
Psychiatric Care
Radiation Treatment
Respiratory Disease
Rheumatic Fever
Shingles
Shortness of Breath
Skin Rash
Stomach / Intestinal Disease
Stroke
Surgical Implants
Swelling (feet , ankles)
Thyroid Problems
Tobacco Use
Tuberculosis
Ulcers / Colitis
Other_____
_____

Women, are you currently:
Pregnant, or trying to get pregnant.
Nursing
Taking Oral Contraceptives Please list any medications, vitamins or herbs you are currently taking:
_____
_____

Known Allergies:
Local Anesthetic
Aspirin
Penicillin
Codeine
Sulfa
Iodine
Latex / Rubber
Other _____ Are you currently under a physicians care? Reason?
_____ Pre-Medication Required?
_____ Have you ever been hospitalized? Reason and Date:
_____
_____ Do you wish to talk to the dentist privately about any problem? Y or N

Please circle if you have had, or are currently experiencing any of these problems:

Active Decay
Bad Breath
Bleeding or Sensitive Gums
Clicking or Popping Jaw: Right or Left
Food Trapped Between Teeth
Grinding or Clenching Teeth
Loose Teeth
Broken Fillings
Periodontal Treatment / Gum Disease
Sensitivity to: Hot or Cold
Sensitivity to sweets
Sensitivity to biting
Sores or Growths in Mouth
Staining

Authorization: I have reviewed the information and answered all questions to the best of my knowledge. I understand this information will be used to determine the dental treatment I receive at this office and may be shared with other medical offices only as necessary. I will notify the office should any information change in the future.

Signature of patient or parent/guardian: _____ Reviewed by:_____