

17840 N. Pennsylvania Ave

Edmond, Ok 73012

(405) 509-2286

 Patient Health History Form

Last Name First MI Preferred name Sex Marital Status

Date of Birth SS# Email address

Mailing Address City State Zip Preferred pharmacy/phone #

Home phone Work phone Ext Cell phone Other

Primary dental insurance Subscriber name Employer DOB SS# or member ID

Name of medical doctor Previous dentist Date of last visit

**Medical Health History:**

Do you have, or have you had, any of the following? (Select yes or no)

**Heart Problems Intestinal Problems**

Chest pains ( )yes ( ) no Ulcers ( )yes ( ) no

Shortness of breath ( )yes ( ) no Kidney problems ( )yes ( ) no

Heart murmur ( )yes ( ) no Swollen glands ( )yes ( ) no

Blood pressure problems ( )yes ( ) no

Heart valve problem ( )yes ( ) no **Bone or Joint Problems**

Taking heart medication ( )yes ( ) no Arthritis/Osteoporosis ( )yes ( ) no

Rheumatic fever ( )yes ( ) no Back or neck pain ( )yes ( ) no

Pace maker ( )yes ( ) no Joint replacement ( )yes ( ) no

Artificial heart valve ( )yes ( ) no Which joint was replaced and when:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Premedication antibiotic ( )yes ( ) no

**Blood Problems Diabetes**

Easy bruising ( )yes ( ) no Family history of diabetes ( )yes ( ) no

Abnormal bleeding ( )yes ( ) no Pre-diabetic/diabetes ( )yes ( ) no

Blood disease (anemia) ( )yes ( ) no Thirsty/Dry mouth ( )yes ( ) no

Blood transfusion ( )yes ( ) no

**Allergies Other**

Local anesthetic ( )yes ( ) no Persistent cough ( )yes ( ) no

Penicillin/Amoxicillin ( )yes ( ) no Snore, gasp when sleeping ( )yes ( ) no

Other antibiotics ( )yes ( ) no Respiratory disease or TB ( )yes ( ) no

Sulfa drugs ( )yes ( ) no Cancer/tumor ( )yes ( ) no

Barbiturates, sedatives ( )yes ( ) no Hepatitis ( )yes ( ) no

Sleeping pills ( )yes ( ) no Jaundice or liver trouble ( )yes ( ) no

Aspirin, Ibuprofen ( )yes ( ) no HIV positive/AIDS ( )yes ( ) no

Acetaminophen ( )yes ( ) no Epilepsy or neurological disease ( )yes ( ) no

Codeine or other narcotics ( )yes ( ) no History of head injury ( )yes ( ) no

Reaction to metals ( )yes ( ) no History of drug/alcohol abuse ( )yes ( ) no

Latex or rubber dam ( )yes ( ) no Do you drink alcohol? ( )yes ( ) no

 Do you smoke? ( )yes ( ) no

 Smokeless Tobacco? ( )yes ( ) no

**Allergy problems** Bone deficiency ( )yes ( ) no

Taking allergy medicine ( )yes ( ) no Fainting/seizures ( )yes ( ) no

Asthma ( )yes ( ) no Frequent/severe headaches ( )yes ( ) no

 Thyroid problems ( )yes ( ) no

**During the past 12 months have you taken any of the following?**

High blood pressure meds ( )yes ( ) no

Blood thinners ( )yes ( ) no

Antibiotics ( )yes ( ) no

Sulfa drugs ( )yes ( ) no

Insulin, Orinase or similar drug ( )yes ( ) no

Aspirin ( )yes ( ) no

Digitalis or drug for heart trouble ( )yes ( ) no

Nitroglycerin ( )yes ( ) no

Cortisone (steroids) ( )yes ( ) no

Natural remedies ( )yes ( ) no

Nonprescription meds ( )yes ( ) no

Tranquilizers ( )yes ( ) no

Bisphosphonates ( )yes ( ) no

**Women**

Are you pregnant? ( )yes ( ) no

If so, how many weeks?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you nursing ( )yes ( ) no

Have you reached menopause? ( )yes ( ) no

**List all medications you are taking currently:**

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**Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_