chesterfield woodlake dental

Health Information

Patient Name ____________________

Date of Last Dental Visit ____________ Reason for Today's Visit ____________

Have you ever had any of the following? Please check and / or circle those that apply:

☐ Acid Reflux
☐ AIDS/HIV/ARC
☐ Alcohol Abuse
☐ Allergy - Aspirin
☐ Allergy - Codeine
☐ Allergy - Latex
☐ Allergy - Other
☐ Allergy - Red Dye
☐ Allergy - Seasonal
☐ Allergy - Sulfa
☐ Allergy - Amoxicillin
☐ Allergy - Dental Anesthetic
☐ Allergy - Penicillin
☐ Anemia
☐ Angioedema
☐ Arthritis / Rheumatism
☐ Artificial Joints
Type ____________
When ____________

☐ Asthma
☐ Blood Clots
☐ Blood Disease
☐ Blood Transfusion
☐ Cancer
Type ____________
☐ Chemotherapy
☐ Chest Pains
☐ Cosmetic Surgery
☐ Dementia
☐ Dental Phobia
☐ Depression
☐ Diabetes
☐ Difficulty Breathing
☐ Disability
☐ Dizziness
☐ Drug Abuse
☐ Excessive Bleeding
☐ Fainting

☐ Growths/Tumors
☐ Head Injuries
☐ Headaches
☐ Heart Attack
☐ Heart Disease
☐ Heart Murmur
☐ Heart Surgery -
Type ____________
☐ Hepatitis - Type ________
☐ High Blood Pressure
☐ Kidney Disease
☐ Liver Disease
☐ Meniere's Disease
☐ Mitral Valve Prolapse
☐ Nervous Disorders
☐ Osteoporosis
☐ Other
____

☐ Pacemaker
Year Placed ____________
☐ Pregnant?
Due Date ____________
☐ Premedication
Needed - Type ____________
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Seizures
☐ Sinus Problems
☐ STD - Type ____________
☐ Stomach Problems
☐ Stroke
☐ Thyroid Problems
☐ TM Disorders
☐ Tuberculosis (TB)
☐ Ulcers

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
- Have you ever had unexplained swelling of the lips, face or neck? ☐ Yes ☐ No
  If yes, please explain: ____________________

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: ____________________

- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ____________________

- Name of Physician: ____________________ Phone: ____________

- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ____________________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____________________ Date: ____________

Signature of Patient, Parent or Guardian

See Reverse Side ➡

CURRENT MEDICATIONS

☐ Not currently taking any medications

Medications you are taking: ____________________

____

____

____

____

____

Signature: ____________________ Date: ____________________

STOP HERE.

MEDICATIONS UPDATE

☐ Not currently taking any medications ☐ SAME AS ABOVE

Medications you are taking: ____________________

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____

____

Signature: ____________________ Date: ____________________

MEDICATIONS UPDATE

☐ Not currently taking any medications ☐ SAME AS ABOVE

Medications you are taking: ____________________

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Signature: ____________________ Date: ____________________

POS Reorder # 1905563