ALLEN AD DENTAL

Health History

Allen Dental is committed to caring for your total well being. Please answer all questions as completely as possible as all questions have relevance to your oral health. If you have any questions and/or need assistance please feel free to ask. Thank You!

Name _____ Today's Date _____

Name of Physician and Clinic _____ Physician's phone _____

Whom may we contact in case of an emergency _____ Contact's Phone _____

Please check your answer

YES NO Any changes in your health in the past year? If so, how?

_____

YES NO Are you currently under the care of a physician? If so, please describe:

_____

YES NO Have you ever had any surgical operation of any kind? If so, please describe:

_____

YES NO Are you currently taking any medication, prescription or non-prescription? If so, name and dosage:

_____

Please write (Y) Yes or (N) No by each medical condition

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disorders
- ☐ Cancer
- ☐ Diabetes
- ☐ Back Problems
- ☐ Chemical Dependency
- ☐ Do you Smoke?
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Hepatitis - Type ( )
- ☐ Pacemaker
- ☐ Respiratory Problems
- ☐ Dizziness
- ☐ Latex Allergy
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Mental Disorder
- ☐ Mitral Valve Prolapse
- ☐ MS
- ☐ Nervous Disorders
- ☐ Rheumatic Fever
- ☐ Stomach Problems
- ☐ Stroke
- ☐ TMJ Pain (click, pop)
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Cold Sores
- ☐ Syphilis
- ☐ Herpes
- ☐ Drug Allergies:

_____

_____

Women

☐ Pregnant

Due Date: _____

☐ Nursing

Do you currently take a pre-med antibiotic before dental treatment? _____

Have you ever had unfavorable reactions to dental materials? _____

Signature _____ Date _____