CONFIDENTIAL HEALTH HISTORY

Office of Dr. Laura Parra

Today's Date: _____

Patient Name: _____ **Date of Birth:** _____
(Last) (First) (Middle) (Preferred)

If you are completing this form for someone else:

Your Name: _____ Phone: (_____) _____ - _____ Relationship: _____

Emergency Contact: (If not listed above)

Name: _____ Phone: (_____) _____ - _____ Relationship: _____

Primary Physician: _____ Phone: (_____) _____ - _____ City/State: _____

Date of last physical examination: _____ Date of last blood test/work up: _____

Other Physicians and Specialists:

Name: _____ Specialty: _____ Phone: (_____) _____ - _____ City/State: _____

Name: _____ Specialty: _____ Phone: (_____) _____ - _____ City/State: _____

Name: _____ Specialty: _____ Phone: (_____) _____ - _____ City/State: _____

Allergies:

Latex----Yes ❑ No ❑ Costume Jewelry----Yes ❑ No ❑ Do you require antibiotic premedication? ---------- Yes ❑ No ❑

Medicines _____ *a*. Do you take any blood thinners? ---------- Yes ❑ No ❑

Foods _____ *b*. Are you or have you taken medications for osteoporosis? ---------- Yes ❑ No ❑

Other _____ If yes, to *a*. or *b*., please list: _____

Current Medications: (Please include prescription, over-the-counter [OTC] and herbal medications.)

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY

Within the last 5 years, have you been hospitalized or had surgery? ---------- Yes ❑ No ❑

If yes, please give reason(s) and date(s): _____

Do you have any history of injuries to your head, neck face or mouth? ---------- Yes ❑ No ❑

If yes, please give reason(s) and date(s): _____

Past and Current Medical Conditions: (Please mark all that apply and explain all "yes" answers on reverse side of form.)

CONDITION	YES	CONDITION	YES	CONDITION	YES
Congenital Heart Defect		Anemia		Sjogren's Disease/Fibromyalgia/Lupus	
Angina or Chest Pain		Hemophilia or Bleeding Disorder		Glaucoma or Other Eye Disease	
Atherosclerosis		Diabetes or Blood Sugar Problems		Epilepsy or Other Seizure Disorder	
Congestive Heart Failure		Artificial Joint/Joint Surgery/Prosthesis		Kidney Problems	
Coronary Artery Disease		Hepatitis/Jaundice/Other Liver Problem		Ulcers/Acid Reflux/Stomach Problem	
Heart Surgery		Cancer		Eating Disorder	
Heart Attack		Chemotherapy/Radiation Treatment		HIV/AIDS	
Rheumatic Heart Disease		Organ Transplant		Sexually Transmitted Disease (STD/VD)	
Infective Endocarditis		Asthma		Depression/Anxiety/Mental Health	
Heart Valve Damage		Hay Fever		Psychiatric Treatment	
Mitral Valve Prolapse		Sinus Problems		Fainting/Dizziness	
Artificial Heart Valve		Tuberculosis or Emphysema		**Women Only:**	
Pacemaker		Sleep Apnea		Are you pregnant?	
Stroke or CVA		A Sore that Bleeds/Does not Heal		Are you nursing?	
High Blood Pressure		Thyroid Disease/Problem		Are you using birth control medication?	
Low Blood Pressure		Arthritis or Other Joint Disorder		Are you taking hormone replacements?	

Tobacco Use:

Do you currently use any type of tobacco product? ---------- Yes ❑ No ❑

If so, what kind, how much and how long have you used tobacco? _____

_____

If you are a former tobacco user, what kind, how much and when did you quit? _____

_____

If you currently use tobacco, are you interested in quitting? ---------- Yes ❑ No ❑

Dental Information:

What is the reason for your visit today? _____

_____

Who was your previous dentist?	How often do you see a dentist?
When was your last dental visit?	When was your last dental cleaning?
How often do you brush?	How often do you floss?

Please mark all positive answers and explain (if needed) below:

	YES		YES
Do you eat or drink sweets between meals?		Do you have a problem with cold sores or blisters?	
Do you use toothpaste with fluoride in it?		Are you aware of any swelling or lumps in your mouth?	
Is your drinking water fluoridated?		Do you have sore or bleeding gums?	
Have you and any fillings within the past year?		Do you have any loose teeth?	
Do you or any of your family have extensive decay problems?		Do you have any difficulty chewing?	
Have you been treated for periodontal (gum) disease?		Does food catch between any of your teeth?	
Have you had braces?		Do your teeth or fillings break frequently?	
Have you had any oral surgery?		Are you aware of clenching and/or grinding your teeth?	
Have you been treated for any temporomandibular disorders?		Do you hear clicking or popping when you open and close?	
Do you have a dry mouth or excessive thirst?		Do you have any jaw pain?	
Do you have any sensitive teeth (hot/cold/pressure/sweets)?		Are you unhappy with the appearance of your teeth?	
Do you have a problem with mouth odor or bad taste?		Are you nervous about dental treatment?	

Additional Information: Please use the space below to explain any "yes" answers above or from the front of the form. In addition, please provide any other information that you think would be important for us to know in order to treat you better.

_____

_____

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CONSENT – I certify that to the best of my knowledge all of the preceding information is correct. I also understand that it is my responsibility to notify this practice of any changes in my health status or medications. I consent to allow this practice to contact other healthcare providers and to share health information to aid in my care and treatment. Finally, I consent to allow the dental practitioners in this office to provide diagnoses and treatments until otherwise notified.

Signature: _____ Date: _____