Patient's Health Information

Patient's Name: _____ Sex: __M __F DOB: ____/____/_____
Address/Facility Address: _____
Facility Name: _____ Facility Contact: _____
Phone: _____ Email: _____

DENTAL HISTORY

Name of Dentist: _____
Date of Last visit & type of treatment: _____
Check if you have problems with any of the following:
__ Bad Breath/ Bleeding gums __ Dry mouth __ Sores or growth in your mouth
__ Food collection between teeth __ Loose teeth __ Ill-fitting partial/denture
__ Other (Please describe)

MEDICAL HISTORY

Name of Physician: _____ Medical Group: _____
Address: _____
MR #: _____ Phone: _____ Email: _____
Are you taking bone density medications or bisphosphonates, such as Fosamax, Boniva, Actenol or IV: Zometa or Aredia in the past 12 years?
__ Yes __ NO

Indicate which of the following you have had or have at present: _ Blind _ Deaf _ Disabled

__ Alzheimer's Disease	__ Bruise easily	__ Emphysema	__ Jaundice	__ Sickle Cell Disease
__ AIDS/HIV	__ Cancer/ Chemotherapy	__ Epilepsy/ Seizures	__ Kidney Trouble	__ Sinus Trouble
__ Alcohol/ Drug Abuse	__ Chest Pain	__ Fainting or Dizzy Spells	__ Liver Disease	__ Snoring/ Sleep Apnea
__ Allergies or Hives	__ Circulatory Problem	__ Frequent Headaches	__ Lupus	__ Stomach Problems
__ Anemia	__ Cold Sores/Herpes	__ Glaucoma	__ Mitral Valve Prolapse	__ Stroke
__ Arthritis/ Rheumatism	__ Cortisone Medicine	__ Heart Pacemaker	__ Nervousness/Anxiety	__ swollen Ankles
__ Artificial Heart Valve	__ Deaf/ Haring loss	__ Heart Problem	__ Neurological Disorder	__Thyroid Problems
__ Artificial Joints **	__ Dementia	__ Hemophilia	__ Parkinson's	__ Tuberculosis
__ Asthma	__ Diabetes	__ Hepatitis A B C	__ Rheumatic Fever	__ Tumors
__ Blood Disease	__ Diet (Special/Restricted)	__ High/Low Blood Pressure	__ Radiation Therapy	__ Ulcer
__ Back/Neck Issues	__ Difficulty Breathing	__ Hospitalized for any Reason	__ Shingles/ Chicken Pox	__ Venereal Disease

If YES to ATIFICIAL JOINTS (HIP/ JOINT REPLACEMENT), an antibiotic **MAY** be required 1 hour prior to appointment. Please have the **MD** prescribe the appropriate antibiotic and have ready on the day of treatment. Take the antibiotic 1 hour prior to the scheduled appointment.
Any other medical conditions not listed:_____

Allergies: __Aspirin __ Penicillin __ Barbiturates (sleeping pills) __ Sulfa __ Codeine __ Latex __ Local Anesthetic

Other_____

List all medications: _____

_____

The above information is accurate to the best of my knowledge. Annik Ohaness, RDHAP, is not responsible for any errors or omissions that I have made while completing this form.

Signature _____ Printed Name_____ Date: _____