Beach Dentistry Health History

Patient Name: _____ Date of Birth:_____

Please check all that apply:

- □ Heart Problems
- □ High Blood Pressure
- □ Angina / Chest Pain
- □ Heart Surgery
- □ Heart Attack
- □ Stroke
- □ Artificial Heart Valve
- □ Congenital Heart Defect
- □ Heart Murmur
- □ Pace Maker
- □ Rheumatic Fever
- □ Excessive bleeding /bruising
- □ Anemia
- □ Blood Transfusion
- □ Hemophilia
- □ Sickle Cell Disease
- □ Methemoglobinemia
- □ HIV+ / AIDS

- □ Allergies
- □ Difficulty Breathing
- □ Asthma
- □ Emphysema
- □ COPD
- □ Sinus Problems
- □ Sleep Apnea
- □ Tuberculosis
- □ Cancer
- □ Chemotherapy
- □ Radiation Therapy
- □ Thyroid Problems
- □ Diabetes I II (circle)
- □ Adrenal disease
- □ Arthritis
- □ Rheumatoid arthritis
- □ Artificial Joint / Joint Replacement

- □ Back / Neck injuries
- □ Pain Management
- □ Gastrointestinal Disease
- □ Acid Reflux (GERD)
- □ Liver Disease
- □ Hepatitis A B C (circle)
- □ Jaundice
- □ Stomach Problems
- □ Venereal Disease
- □ Kidney Problems
- □ Organ Transplant
- □ Fainting Spells
- □ Neurological Problems
- □ Epilepsy
- □ Seizures
- □ Frequent Headaches
- □ Fibromyalgia

- □ Alcohol use
- □ Tobacco ___packs/day
- □ Recreational Drugs
- □ Psychiatric Care
- □ Eating Disorder
- □ Shingles
- □ Cold Sores / Fever Blisters
- □ Autism
- □ Facial Pain
- □ Contact Lenses
- □ Glaucoma
- □ Hearing Impaired

Women Only:

- □ Pregnant
- □ Nursing
- □ Oral Contraceptives

Allergies:

□ Latex □ Penicillin □ Other Antibiotic:_____

□ Ibuprofen □ Aspirin □ Local Anesthetics □ Iodine □ Sedatives □ Codeine □ Metals

□ Other:_____ **Please describe reaction:**_____

Please list any other medical conditions not mentioned: _____

_____

_____

Please list the medications you are taking:

_____

_____

_____

Primary Care Physician: _____ **Telephone:**_____

Recent hospitalizations or surgeries? YES NO

Have you ever had an emergency in a dental office requiring medical attention? YES NO

Have you ever taken an oral or IV bisphosphonate medication (*Fosamax, Boniva, Actonel, etc.)*? YES NO

Does your doctor require you to take antibiotics prior to dental procedures? YES NO

I certify that this is an accurate and complete history of my health. I agree to notify Beach Dentistry of any changes in my health and medications at each appointment. I authorize Beach Dentistry to contact my primary care physician, my other medical specialists, and pharmacies regarding my health conditions, medications, and continuing care.

Patient Signature: **Today's Date:**

Doctor Notes:

Doctor Signature:_____ Date:_____