Advanced Dental Care Center

Patient Health History Information Form

For Office Use Only:
Initial BP: _____/_____ Date:_____
Doctor Signature: _____

Patient First Name: _____ **Last Name:** _____

Male/Female **Married/Single/Child** **Date of Birth** ___/___/_____ **SS#** _____-_____-_____

Address: _____

City: _____ **State:** _____ **Zip Code:**_____

Phone: _____ **Alternate #:** _____

Email Address: _____

Emergency Contact Person: _____ **Phone:** _____

Do you currently have or have you ever had a history of: (please place an "X" on all the circles that relate to your condition)

- o AIDS/HIV Positive
- o Alcoholism
- o Allergies
- o Anemia
- o Arthritis
- o Asthma
- o Blood Disease
- o Bone Disease
- o Cancer
- o Chemical Dependency
- o Circulatory Problems
- o Convulsions/Seizure
- o Diabetes
- o Epilepsy
- o Excessive Bleeding
- o Glaucoma
- o Hay Fever
- o Head Injuries
- o Hearing Impaired
- o Heart Disease
- o Heart Valve, Murmur
- o Hepatitis , Type ___
- o Hepatitis Carrier, Type ___
- o High Blood Pressure
- o HPV
- o Jaundice
- o Kidney Disease
- o Kidney Dialysis
- o Latex Allergy
- o Low Blood Pressure
- o Liver Disease
- o Lupus
- o Malignancies
- o Mental Disorders
- o Mitral Valve Prolapse
- o Nervous Disorders
- o Pacemaker
- o Prosthetic Joints
- o Psychiatric Care
- o Radiation Treatment
- o Respiratory Problems/Disorders
- o Rheumatic Fever
- o Rheumatism
- o Scarlet Fever
- o Seizures/Fainting Spells
- o Sinus Problems
- o Stomach Ulcers
- o Stroke
- o Thyroid Disease
- o Tuberculosis
- o Tumors/Growths
- o Ulcers
- o Venereal Disease

For Women Only:
Are you currently Pregnant? Yes or No
If Yes, due date: ___/___/_____
Are you nursing? Yes or No

1. **Have you ever been told by your physician to take any Antibiotic Pre-Medication before any Dental Treatment? Yes or No**
2. **Do you smoke or chew tobacco? Yes or No**

List any medications that you are taking including non-prescription drugs:

_____
_____

List any medications that you are ALLERGIC to:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Do your gums bleed when brushing or eating?
- o Yes
- o No

Are your teeth sensitive to Hot or Cold?
- o Yes
- o No

Do you ever clench or grind your teeth?
- o Yes
- o No

Signature of Patient (parent or guardian, if a minor): _____ **Date:** ____/_____/_____

I certify that to the best of my ability, this form has been completed to my satisfaction. I will not hold the dentist or any of his staff responsible for any errors that I have made while completing this form.

Health Hx Reviewed by: _____ Dentists Signature: _____