

## Patient History and Information

(Please print clearly)

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Approximate Weight: \_\_\_\_\_ Approximate Height: \_\_\_\_\_

**Medications, Vitamins, Herbals, etc. taken regularly: (attach list if prepared in advance)**

Medication Name	Strength	Dosage
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(list additional on back of this page)

**Allergies to Medications:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Previous Operations and Approximate Date (most recent listed first):**

Operation	Year
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

(list additional on back of this page)

**Previous Major Illnesses and conditions (most recent listed first):**

Illness	Year
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

(list additional on back of this page)

## Patient History and Information

**Current Diagnosis** (Reason for Consultation): \_\_\_\_\_

List other physicians you are currently seeing: \_\_\_\_\_

When did you last see your dentist? \_\_\_\_\_

Circle Yes or No

Do you have any dental work pending or needed? Yes No

Do you have loose teeth, dentures, or caps on your teeth? Yes No

Do you currently have any rashes, hives, or other skin conditions? Yes No

Have you ever had high blood pressure? Yes No

Have you ever smoked? Yes No

How many years? \_\_\_\_\_ Number of packs per day \_\_\_\_\_

If you have quit smoking, when did you quit? \_\_\_\_\_

Have you ever had asthma? Yes No

Do you get short of breath? Yes No

Have you ever had a heart attack? Yes No

Have you ever had an irregular heart beat? Yes No

Do you have any bleeding tendencies? Yes No

Have you ever had yellow jaundice or hepatitis? Yes No

Have you ever given yourself intravenous drugs? Yes No

Have you had possible exposure to AIDS? Yes No

Have you ever had a stroke? Yes No

Have you ever had kidney disease? Yes No

Do you have diabetes? Yes No

Are you insulin dependant? Yes No

Do you drink alcohol? Yes No

How much? \_\_\_\_\_ How often? \_\_\_\_\_

Signature of Patient \_\_\_\_\_

Date Completed \_\_\_\_\_

## **Patient History and Information**