

Premier Community HealthCare Group, Inc.

HEALTH HISTORY - DENTAL

PATIENT NAME: _____

DATE: _____

DATE OF BIRTH: _____

EMERGENCY CONTACT: _____

PHONE: _____

RELATIONSHIP: _____

Physician _____ Phone _____

Date last exam _____

Are you under medical treatment now?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you ever been hospitalized for surgery or illness?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are you taking medications (drugs) now?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes to any of these questions, please explain: _____		

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

High Blood Pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Chest Pains	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Anemia	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Low Blood Pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Swollen Ankles	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Leukemia	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart Pacemaker	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Kidney Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Bleeding Problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Irregular Heart Beat	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Arthritis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Thyroid Problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart Murmur	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Cancer	Yes <input type="checkbox"/>	No <input type="checkbox"/>	HIV/AIDS	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Tuberculosis(TB)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Stroke	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Rheumatic Fever	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Hepatitis/Jaundice	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Stomach Ulcers	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart Attack	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Hemophilia	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Liver Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Angina	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Radiation Therapy	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Joint Replacement	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Sexual Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Chemotherapy	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Asthma/Emphysema	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Seizures	Yes <input type="checkbox"/>	No <input type="checkbox"/>			
Last Attack _____			Last Seizure _____					

Please list or explain any other Medical Problem not indicated above: _____

Please list what you are **ALLERGIC** to or have a **REACTION** to:

ARE YOU WEARING CONTACT LENSES? Yes No

- Do you use Tobacco? Yes No If yes, please check all that apply Cigarettes Packs per day _____
 Chewing Tobacco Cigar
 Snuff Pipe
- How many years have you used tobacco? _____ If you quit, when? _____
- Do you sometimes use Marijuana or other drugs socially? Yes No If so, how often? _____
- Do you use Alcohol? Yes No In a week, how much? Beer _____ Wine _____ Liquor _____

TO BE COMPLETED BY FEMALES ONLY

- Are you Pregnant or think you may be Pregnant? Yes No
 - Are you Nursing (breast feeding)? Yes No
 - Are you taking Birth Control Pills? Yes No
 - Do you have problems with your menstrual cycle? Yes No
 - Or if pregnant, your pregnancy? Yes No
- If yes, please explain? _____

DENTAL HISTORY

Last Dental visit was _____. What was done? _____

FINALLY, ARE YOU IN PAIN NOW?

Yes No

If yes, please explain where it is, what it's like and for how long: _____

Comments you'd like to share with Dentist or staff? _____

your signature