Print Form

West River Dental Health History

Name _____ Date _____

Date of last medical exam or physical: _____What was this exam for? _____

Have you been hospitalized in the last 5 years? No ◯ Yes ◯

If yes, reason: _____

Are you currently receiving care? No ◯ Yes ◯ If yes, nature of care: _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____
2. _____
3. _____
4. _____

*For the following questions select **yes or no**. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.*

	No	Yes		No	Yes
Heart Murmur (mitral valve prolapse)	◯	◯	Sore/Enlarged Lymph Nodes	◯	◯
Heart (surgery, disease, attack or abnormality) please explain;	◯	◯	Emphysema or Respiratory Illnesses	◯	◯
			Abnormal Bleeding from a cut	◯	◯
			Slow-Healing Mouth Sores	◯	◯
			Recurrent Illnesses	◯	◯
Diabetes	◯	◯	Other Disease/Infections	◯	◯
Joint Replacement & type	◯	◯	Previous Biopsies	◯	◯
Asthma	◯	◯	Psychosis	◯	◯
Rheumatic Fever	◯	◯	Anemia	◯	◯
Hepatitis, Any Form	◯	◯	Taken Fen-phen or other diet pills	◯	◯
HIV Positive or AIDS Related Complex	◯	◯	Liver Disease (including Jaundice)	◯	◯
Kidney Disease	◯	◯	Unintentional Weight Loss/Gain	◯	◯

Are you taking any of these medications?	No	Yes		No	Yes
Pre-medication before dental treatment?	◯	◯	Tagamet (Cimetidine)?	◯	◯
Antacids?	◯	◯	Herbal supplements?	◯	◯
Have you been treated with Bisphosphonate drugs? Fosamax, Actonel, etc…				◯	◯

Please list any medications you are currently taking:

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

Women: Are you pregnant? No ◯ Yes ◯
If no, are you planning a pregnancy in the near future? No ◯ Yes ◯
Are you a nursing mother? No ◯ Yes ◯
Are you taking birth control pills? No ◯ Yes ◯

Abnormal Blood Pressure? (Please circle) No ◯ Yes ◯
If yes, what is it usually: High ◯ Low ◯ S ☐ /D ☐

Are you allergic or have you had a reaction to:

a. Local anesthetics …….. No ◯ Yes ◯
b. Penicillin or other antibiotics ……..…… No ◯ Yes ◯
c. Aspirin ….……..……... No ◯ Yes ◯
d. Codeine, valium or other sedatives ……...……... No ◯ Yes ◯
e. Latex…….. No ◯ Yes ◯
f. Other _____

Are you a smoker? No ◯ Yes ◯
If yes, how much do you smoke per day? _____

Weight: _____

Diet: Restricted Diet _____
Food Allergies _____
Sugar in your diet: ☐ None ☐ Slight ☐ Moderate ☐ High

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

_____ _____ _____
Patient (Print Name) ***Patient /Legal Guardian Signature*** ***Date***

Dan R Greenhalgh DMD _____ _____
Doctor (Print Name) ***Doctor Signature*** ***Date***

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Comments on patient interview concerning medical history:
_____
_____

Significant findings from questionnaire or oral interview:
_____
_____

Dental management considerations:
_____
_____

INFORMATION UPDATE

Have you had a change in your health since your last visit? No Yes

Heart (Surgery, Disease, Attack)	No	Yes	Hepatitis, Any Form	No	Yes
Heart Murmur (mitral valve prolapse)	No	Yes	Rheumatic Fever	No	Yes
Joint Replacement & type	No	Yes	H.I.V. Infection/AIDS	No	Yes
Taken Fen-phen or other diet pills	No	Yes	Other Disease/Infections	No	Yes

Other: _____
Have you had a visit to a physician since your last dental visit? No Yes

Women: Are you pregnant? No Yes Are you a nursing mother? No Yes

Please list any medications you are currently taking:
1. _____ 3. _____
2. _____ 4. _____

Do you have any allergies? No Yes List: _____

Notes: _____
_____
_____

Signature _____Date _____

Signature _____Date _____

Signature _____Date _____