FOR OFFICE USE ONLY
Chart # «Chart»
Patient Name: «FName» «LName»
DOB: «BirthDate»
Reviewed By:

MAHEC DENTAL HEALTH CENTER AND CENTER FOR ADVANCED TRAINING

HEALTH INFORMATION

Date of last dental visit: _____ Reason for today's visit_____

Please list ALL ***medications***, supplements (including herbals), and over-the-counter medications you are currently taking:

Please list any ***allergies***, including non-medication allergies (metals, latex, etc.):

WOMEN, are you: ☐ Pregnant, Due Date: _____ ☐ Nursing

☐ Taking Oral Contraceptives ☐ Trying to get pregnant

Have you ever been hospitalized or had a major operation? Yes or No (Circle one) If yes, please provide details:

_____

_____

Have you ever taken Fosamax, Boniva, or any other medications containing Bisphosphonates?
Yes or No (Circle one) If yes, are you currently taking OR when was your last time taking?

_____

_____

Do you require antibiotics before dental treatment? Yes or No (Circle One) If yes, for what condition?

_____

Do you use, or have you ever used, any tobacco products (smoking, chewing, dipping, vaping, etc.)?

_____

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In the following sections, please check if you currently have, have had, and/or are being treated for any of the below conditions

Heart/Blood/Cardiovascular	
☐ High Blood Pressure	☐ Congenital Heart Problems
☐ Heart Attack	☐ Heart Murmur
☐ Stroke	☐ Bruise Easily
☐ Chest Pain/Angina	☐ Mitral Valve Prolapse
☐ Irregular Heart Beat/A-fib	☐ Scarlet or Rheumatic Fever
☐ Excessive Bleeding	☐ Blood Transfusion
☐ AID/HIV Positive	☐ Anemia
☐ Leukemia	☐ Sickle Cell Disease
☐ Infective Endocarditis	☐ Low Blood Pressure
☐ Artificial Heart Valve	☐ Pace Maker
☐ Heart Failure	☐ Other Heart Problems

Skin/Joint/Muscle/Skeletal/Autoimmune/Other	
☐ Cancer	☐ Fibromyalgia
☐ Radiation Therapy	☐ Lupus
☐ Chemotherapy	☐ Cortisone Medications
☐ Osteoporosis	☐ Swelling of the Limbs
☐ Rheumatoid Arthritis	☐ Gout
☐ Artificial Joints	☐ Hives or Rash
☐ Head/Neck Injury	☐ Dry Mouth
☐ Pain in the Jaw Joints	☐ Sores in or Around the Mouth
☐ Glaucoma	☐ Herpes, Shingles, or Other Veneral Diseases

Psychiatric/Neurologic	
☐ Depression	☐ Drug Addiction
☐ Bipolar Disorder	☐ Seizures or Convulsions
☐ Anxiety	☐ Developmental Disorders
☐ Schizophrenia	☐ Autism (spectrum)
☐ ADHD	☐ Fainting Spells or Dizziness
☐ Dementia or Alzheimer's Disease	☐ Other Psychiatric Condition

Liver/Kidney/Gastrointestinal
☐ Hepatitis A
☐ Hepatitis B or C (circle one)
☐ Frequent Heartburn/Acid Reflux
☐ Kidney Problems
☐ Stomach Ulcers
☐ Frequent Diarrhea
☐ Other kidney problem
☐ Other liver disease or problem

Breathing and Lungs
☐ Asthma
☐ COPD
☐ Sleep Apnea
☐ Shortness of Breath
☐ Tuberculosis
☐ Sinus Conditions/Trouble
☐ Frequent Cough
☐ Other Breathing/Lung Problems

Diabetes/Thyroid	
☐ Diabetes	☐ Excessive Thirst
☐ Thyroid Disease	☐ Recent Weight Loss
☐ Low Blood Sugar	

Do you have a Primary Care Provider? Circle one: Yes No

If yes, Please list a name and telephone number: _____

What is your preferred pharmacy (please list name, address, and phone number)?

_____

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Do you have any health problems that need further clarification? ☐ Yes ☐ No

If YES, please explain: _____

_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian_____ Date_____