HAYES
GENERAL & COSMETIC DENTISTRY

Patient Health History

PATIENT NAME _____ BIRTH DATE: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication(s) that you may be taking could have an important interrelationship with the dental care you will receive in our office. Please complete the following questionnaire. Thank you

Are you under a physician's care now? ☐Yes ☐ No If yes, please explain: _____

Physicians Name _____ **Phone** _____

Are you taking any medications? ☐Yes No☐ If yes, please list: _____

Have you ever been hospitalized or had a major operation? ☐Yes ☐No If yes, please explain: _____

Have you ever had a serious head or neck injury? ☐Yes ☐No If yes, please explain: _____

Do you take, or have you taken, Pen-Fen or Redux? ☐Yes ☐ No If yes, when? _____

Do you consume alcohol? ☐Yes ☐No If yes, how much per day / week / month? _____

Do you Smoke Tobacco or Chew Tobacco? ☐Yes ☐No **Do you use illicit drugs?** ☐Yes ☐No If yes, indicate _____

Have you ever had psychiatric treatment? ☐Yes ☐No If so, please explain _____

Women: Are you Pregnant/Trying to get pregnant? ☐Yes ☐No Taking oral contraceptives? ☐Yes ☐No Nursing? ☐Yes ☐No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Sulfa Drugs

Other, please explain: _____

Do you have, or have you had, any of the following? Please check Yes or No

Alzheimer's disease ☐Yes ☐No	Cortisone Medicine ☐Yes ☐No	Hemophilia ☐Yes ☐No	Recent Weight Loss ☐Yes ☐No
Anaphylaxis ☐Yes ☐No	Diabetes ☐Yes ☐No	Hepatitis A ☐Yes ☐No	Renal Dialysis ☐Yes ☐No
Anemia ☐Yes ☐No	Easily Winded ☐Yes ☐No	Hepatitis B or C ☐Yes ☐No	Rheumatic Fever ☐Yes ☐No
Angina ☐Yes ☐No	Emphysema ☐Yes ☐No	HIV/AIDS ☐Yes ☐No	Rheumatism ☐Yes ☐No
Arthritis/Gout ☐Yes ☐No	Epilepsy or Seizures ☐Yes ☐No	High Blood Pressure ☐Yes ☐No	Scarlet Fever ☐Yes ☐No
Artificial Heart Valve ☐Yes ☐No	Excessive Bleeding ☐Yes ☐No	Hives or Rash ☐Yes ☐No	Shingles/Herpes Zoster ☐Yes ☐No
Artificial Joint ☐Yes ☐No	Excessive Thirst ☐Yes ☐No	Hypoglycemia ☐Yes ☐No	Sickle Cell Disease ☐Yes ☐No
Asthma ☐Yes ☐No	Fainting Spells/Dizziness ☐Yes ☐No	Irregular Heartbeat ☐Yes ☐No	Sinus Trouble ☐Yes ☐No
Blood Transfusion ☐Yes ☐No	Frequent Cough ☐Yes ☐No	Kidney Problems ☐Yes ☐No	Stomach/Intestine Disease ☐Yes ☐No
Breathing Problem ☐Yes ☐No	Frequent Diarrhea ☐Yes ☐No	Leukemia ☐Yes ☐No	Stroke ☐Yes ☐No
Bruise easily ☐Yes ☐No	Frequent Headaches ☐Yes ☐No	Liver Disease ☐Yes ☐No	Swelling of Limbs ☐Yes ☐No
Cancer ☐Yes ☐No	Glaucoma ☐Yes ☐No	Low Blood Pressure ☐Yes ☐No	Thyroid Disease ☐Yes ☐No
Chemotherapy ☐Yes ☐No	Hay Fever ☐Yes ☐No	Lung Disease ☐Yes ☐No	Tonsillitis ☐Yes ☐No
Chest Pains ☐Yes ☐No	Heart Attack/Failure ☐Yes ☐No	Mitral Valve Prolapse ☐Yes ☐No	Tuberculosis (T.B.) ☐Yes ☐No
Cold Sores/Fever Blisters ☐Yes ☐No	Heart Murmur ☐Yes ☐No	Pain in Jaw Joints ☐Yes ☐No	Tumors or Growths ☐Yes ☐No
Congenital Heart Disorder ☐Yes ☐No	Heart Pace Maker ☐Yes ☐No	Parathyroid Disease ☐Yes ☐No	Ulcers ☐Yes ☐No
Convulsions ☐Yes ☐No	Heart Trouble/Disease ☐Yes ☐No	Radiation Treatments ☐Yes ☐No	Yellow Jaundice ☐Yes ☐No

Have you ever had or do you have any serious illness not listed above? ☐Yes ☐No If yes, please explain: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in my medical status.

_____ _____

Patient/Guardian Signature Date