SVT Health&Wellness *Your Community Health Center!*

# HEALTH HISTORY DENTAL

Patient Name: _____

Date of Birth: ___/___/_____

| Current Medications, supplements, etc.: | | |
|---|---|---|
| | | |
| | | |

Allergies: ☐ Penicillin ☐ Codeine ☐ Latex ☐ Other: _____

Date of last Dental Exam: _____

Date of last Dental Visit: _____

Any history of complications following Dental Treatment? ☐ Yes ☐ No

If YES, explain: _____

Any chance you are pregnant? ☐ Yes ☐ No Nursing Mother? ☐ Yes ☐ No

Do you use: ☐ Tobacco ☐ Alcohol ☐ Marijuana ☐ Other Drugs

Date of last Medical Exam: _____

Name of Primary Physician: _____

Have you ever had a joint replaced or any heart conditions? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Are you happy with your smile? ☐ Yes ☐ No

List past hospitalizations/surgeries: _____

Please Check Conditions that Apply to You in the Past or Present

| | | |
|---|---|---|
| ☐ Anemia | ☐ Head Injury | ☐ Prostate Problems |
| ☐ Anxiety | ☐ Heart Disease | ☐ Radiation Therapy |
| ☐ Arthritis | ☐ Heart Murmur | ☐ Rheumatic Fever |
| ☐ Artificial Joints | ☐ Heart Valve | ☐ Seizures |
| ☐ Asthma | ☐ Hepatitis | ☐ Sexually Transmitted Diseases |
| ☐ Bleeding Conditions | ☐ High Blood Pressure | ☐ Stroke |
| ☐ Bone/Muscle Problems | ☐ HIV | ☐ Thyroid |
| ☐ Breathing Problems | ☐ Kidney Problems | ☐ TMJ |
| ☐ Cancer | ☐ Liver Disease | ☐ Treatment for Osteoporosis |
| ☐ Chemotherapy | ☐ Migraines | ☐ Tuberculosis / Positive TB Test |
| ☐ Depression | ☐ Pacemakers or Defibrillator | ☐ Urinary Problems |
| ☐ Diabetes | ☐ Parathyroid Problems | |
| ☐ I have taken a medicine called: Fosamax, Alendronate, Risedronate, Actonel, Reclast, Bisphosophonate | | |
| ☐ Other: | | |

Notes:

**Patient Signature:** **Date:** Provider Initial: Date: