

# DENTISTRY AT HICKORY FLAT

**PATIENT NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important inter-relationship with the dental treatment you will receive.

What would you rate your anxiety level for Dental Treatment?  Low       Average       slightly above Average       High

**Have you been told you need PRE-MEDICATED before dental treatment and/or cleaning?**  YES       NO

Are you under a physician's care?       YES       NO      if yes please explain \_\_\_\_\_

Have you ever been hospitalized or had major surgery?       YES       NO      if yes please explain \_\_\_\_\_

Have you ever had a serious head or neck injury?       YES       NO      if yes please explain \_\_\_\_\_

Do you, or have ever taken Phen-Fen or Redux?       YES       NO      if yes please explain \_\_\_\_\_

Are you on a special Diet?       YES       NO      if yes please explain \_\_\_\_\_

Do you use tobacco products?       YES       NO      If yes how often \_\_\_\_\_

Do you use controlled substances?       YES       NO      if yes please explain \_\_\_\_\_

ARE YOU TAKING ANY MEDICATIONS?       YES       NO      if yes please explain \_\_\_\_\_

**Women Only:** Are you pregnant or trying to get pregnant?       YES       NO      if yes how far along are you \_\_\_\_\_

Taking oral contraceptives?       YES       NO      Nursing?  YES       NO

**ALLERGIES: please check all that apply**

Latex     Codeine     Acrylic     Sulfa     Aspirin     Penicillin     Metal     Local Anesthetics     Erythromycin

Other: \_\_\_\_\_

**Do you or have you ever had any of the following: *Please check all that apply***

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Anemia               | <input type="checkbox"/> High Cholesterol  | <input type="checkbox"/> Arthritis                  | <input type="checkbox"/> Jaundice              |
| <input type="checkbox"/> Artificial Joints    | <input type="checkbox"/> Kidney Disease  | <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Liver Disease         |
| <input type="checkbox"/> Low Blood Pressure   | <input type="checkbox"/> Blood disease   | <input type="checkbox"/> Back Problems              | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Cancer               | <input type="checkbox"/> Migraine Headaches  | <input type="checkbox"/> Cold Sore/Fever Blister    | <input type="checkbox"/> Hypoglycemia          |
| <input type="checkbox"/> Nervous Disorder     | <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Physical Disability        | <input type="checkbox"/> Head / Neck Injuries  |
| <input type="checkbox"/> Depression           | <input type="checkbox"/> Psychiatric Problems  | <input type="checkbox"/> Drug addiction             | <input type="checkbox"/> Stroke                |
| <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Epilepsy/Seizures   | <input type="checkbox"/> Radiation /Chemo           | <input type="checkbox"/> TM J (jaw joint pain) |
| <input type="checkbox"/> Excessive Bleeding   | <input type="checkbox"/> Respiratory/ Breathing Problems   | <input type="checkbox"/> Fainting/Dizzy spells      | <input type="checkbox"/> Tuberculosis          |
| <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Sinus/ Hay Fever  | <input type="checkbox"/> HIV Positive               | <input type="checkbox"/> Tumor or growth       |
| <input type="checkbox"/> Stomach Problems     | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Rheumatic or Scarlet Fever | <input type="checkbox"/> Heart Murmur          |
| <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Hepatitis ( <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C) | <input type="checkbox"/> Thyroid Disease            |  |

Other: \_\_\_\_\_

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 the patient's health. It is my responsibility to inform the dental office of any changes & updates to my medical health status.

**Signature:** \_\_\_\_\_

**Date :** \_\_\_\_\_