NORTHERN HEALTH CENTERS

Dental Health History Form

PATIENT NAME: _____ **MRN:** _____ **DOB:**_____/_____/_____

Dental personnel primarily treat the area in and around your mouth. The mouth is part of your entire body and health problems that you may have and/or medication you may be taking could have an interrelationship with the dental care you will receive. Please answer the following questions. Thank you.

IF YOU ANSWER YES TO ANY QUESTION BELOW, PLEASE EXPLAIN ON THE LINES BELOW

Who is your medical doctor or clinic?		
Have you ever been hospitalized or had a major operation?	Y N	
Have you ever had a serious head or neck injury?	Y N	
Do you use prescription pain medications or recreational drugs?	Y N	
Are you on a special diet?	Y N	
Do you have any type of disability?	Y N	
Have you been told to pre-medicate prior to dental visits?	Y N	
Are you taking any blood thinners such as aspirin regularly?	Y N	
Are you on or have you taken osteoporosis medications?	Y N	Please circle Fosamax Boniva Actonel Didronel Reclast Skelid Zometa
Do you use chewing, smoking tobacco or electronic cigarettes?	Y N	
Are you taking any medication, pills or drugs?	Y N	If yes, please list them below along with proper dosages

MEDICATION LIST: It is very important we have a list of ALL of your medications to properly treat you. Please continue on back if needed.

_____ _____
_____ _____
_____ _____

WOMEN: Are you pregnant or trying to become pregnant? Yes No Taking oral contraceptive? Yes No Nursing? Yes No
Name of Gynecologist/Obstetrician: _____

Are you allergic to any of the following?
☐ **Aspirin** ☐ **Penicillin** ☐ **Codeine** ☐ **Acrylic** ☐ **Metal** ☐ **Latex** ☐ **Local Anesthetics** ☐ **Other Allergies**
Please explain: _____

DO YOU CURRENTLY HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?
(PLEASE CIRLE YES OR No to each question)

AIDS/HIV Positive	Y N	Convulsions	Y N	Heart Pace Maker	Y N	Radiation Treatment	Y N
Anaphylaxis	Y N	Diabetes Type I Type II	Y N	Heart Trouble/Disease	Y N	Recent Weight Loss	Y N
Anemia/Sickle Cell Disease	Y N	Drug or Alcohol Addiction	Y N	Hemophilia	Y N	Behavioral Health Issues	Y N
Angina	Y N	Easily Winded	Y N	Hepatitis A B C (please circle)	Y N	Renal Dialysis	Y N
Arthritis/Gout	Y N	Emphysema or COPD	Y N	Herpes (Oral)	Y N	Rheumatic Fever	Y N
Artificial Heart Valve	Y N	Epilepsy or Seizures	Y N	High Blood Pressure	Y N	Rheumatism	Y N
Artificial Joint (s)	Y N	Excessive Bleeding	Y N	Hives or Rash	Y N	Scarlet Fever	Y N
Asthma	Y N	Excessive Thirst	Y N	Hypoglycemia	Y N	Shingles	Y N
Blood Disorder	Y N	Fainting Spells/Dizziness	Y N	Irregular Heartbeat	Y N	Sinus Trouble	Y N
Blood Transfusion	Y N	Frequent Cough	Y N	Kidney Problems	Y N	Stomach/ Intestinal Disease	Y N
Breathing Problem	Y N	Frequent Diarrhea	Y N	Leukemia	Y N	Stroke	Y N
Bruise Easily	Y N	Frequent Headaches	Y N	Liver Disease / Yellow Jaundice	Y N	Swelling of Limbs	Y N
Cancer _____	Y N	Genital Herpes or other STDs	Y N	Low Blood Pressure	Y N	Tonsillitis	Y N
Chemotherapy	Y N	Glaucoma	Y N	Lung Disease	Y N	Tuberculosis	Y N
Chest Pain	Y N	Hay Fever / Seasonal allergies	Y N	Pain in Jaw Joints	Y N	Tumors or Growths	Y N
Cold Sores/Blisters	Y N	Heart Attack/Failure	Y N	Parathyroid/Thyroid Disease	Y N	Ulcers	Y N
Congenital Heart Disorder	Y N	Heart Murmur	Y N	Psychiatric Care	Y N	Neurological disorder	Y N

Preferred pharmacy _____ **Phone number (_____) ____-_____**

Have you ever had any serious illness not listed above? ___Y ____ N If yes, please_____

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 Northern Health Centers, Inc., dental clinic of any changes in medical status. I give consent for myself/my child to receive dental treatment as explained to me by the providers at Northern Health Centers, Inc.

Signature: _____ ***Date:***_____

Doctor's Signature: _____ ***Date:***_____

Additional Medications

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____