Grace Health

Dental Health History

Patient Name _____ Date _____ Birthdate _____

Past Medical History: *(please check all that apply)*

❑ Asthma	❑ AIDS	❑ Bleeding disorders	❑ Cancer (Type/Location_____)
❑ Cardiac arrhythmia	❑ Cirrhosis	❑ Chest pain	❑ Heart attack (Date_____)
❑ COPD	❑ Defibrillator	❑ Diabetes	❑ Organ transplant (Organ_____)
❑ Dialysis	❑ Epilepsy	❑ Congenital heart disease	❑ Stent placement (Date_____)
❑ Hepatitis	❑ HIV	❑ Seizures	❑ Stroke (Date_____)
❑ Joint replacement	❑ Pacemaker	❑ Thyroid disease	❑ Prosthetic (artificial) heart valve
❑ High blood pressure	❑ Kidney disease	❑ Infective endocarditis	❑ Head/neck radiation treatment

General Information

Do you have an Advance Directive? ❑ Yes ❑ No ❑ Don't Know ❑ Want Information

Do you have a primary care (medical) provider? ❑ Yes ❑ No

Have you ever taken bisphosphonate medication (Zometa, Didronal, Fosamax, Boniva, Reclast)? ❑ Yes ❑ No

Do you use tobacco products? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No

Current Medications/Over-the-Counter/Vitamins/Herbs: *(if you don't know the name, please indicate why you take them)*

_____

_____

_____

_____

Allergies

Medications _____

Other (food, latex, environmental) _____

Dental Information

Why are you seeing the dentist today?

_____

Do you have dental pain or discomfort? If yes, please indicate location.

_____

Do you wear dentures or partials? ❑ Yes ❑ No

Do you have any dental implants? ❑ Yes ❑ No