PREMIER COMMUNITY HEALTHCARE GROUP, INC.

HEALTH HISTORY – DENTAL

PATIENT NAME: _____ DOB: _____ Acct. #: _____
TODAY'S DATE: _____

EMERGENCY CONTACT: _____ PHONE: _____
RELATIONSHIP: _____

Physician _____ Phone _____ Date last exam _____

Are you under medical treatment now?	Yes ☐	No ☐
Have you ever been hospitalized for surgery or illness?	Yes ☐	No ☐
Are you taking medications (drugs) now?	Yes ☐	No ☐

If yes to any of these questions, please explain: _____
_____
_____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

High Blood Pressure	Yes ☐	No ☐	Chest Pains	Yes ☐	No ☐	Anemia	Yes ☐	No ☐
Low Blood Pressure	Yes ☐	No ☐	Swollen Ankles	Yes ☐	No ☐	Leukemia	Yes ☐	No ☐
Heart Pacemaker	Yes ☐	No ☐	Kidney Disease	Yes ☐	No ☐	Bleeding Problems	Yes ☐	No ☐
Irregular Heart Beat	Yes ☐	No ☐	Arthritis	Yes ☐	No ☐	Thyroid Problems	Yes ☐	No ☐
Heart Murmur	Yes ☐	No ☐	Cancer	Yes ☐	No ☐	HIV/AIDS	Yes ☐	No ☐
Tuberculosis(TB)	Yes ☐	No ☐	Stroke	Yes ☐	No ☐	Diabetes	Yes ☐	No ☐
Rheumatic Fever	Yes ☐	No ☐	Hepatitis/Jaundice	Yes ☐	No ☐	Stomach Ulcers	Yes ☐	No ☐
Heart Attack	Yes ☐	No ☐	Hemophilia	Yes ☐	No ☐	Liver Disease	Yes ☐	No ☐
Heart Disease	Yes ☐	No ☐	Angina	Yes ☐	No ☐	Radiation Therapy	Yes ☐	No ☐
Joint Replacement	Yes ☐	No ☐	Sexual Disease	Yes ☐	No ☐	Chemotherapy	Yes ☐	No ☐
Asthma/Emphysema	Yes ☐	No ☐	Seizures	Yes ☐	No ☐			
Last Attack _____			Last Seizure _____					

Please list or explain any other Medical Problem not indicated above: _____
_____

Please list what you are <u>ALLERGIC</u> to or have a <u>REACTION</u> to:
_____

ARE YOU WEARING CONTACT LENSES? Yes ☐ No ☐

- Do you use Tobacco? Yes ☐ No ☐ If yes, please check all that apply Cigarettes ☐ Packs per day ____
  Chewing Tobacco ☐ Cigar ☐
  Snuff ☐ Pipe ☐
- How many years have you used tobacco? _____ If you quit, when? _____
- Do you sometimes use Marijuana or other drugs socially? Yes ☐ No ☐ If so, how often? _____
- Do you use Alcohol? Yes ☐ No ☐ In a week, how much? Beer _____ Wine _____ Liquor _____

TO BE COMPLETED BY FEMALES ONLY

- *Are you Pregnant or think you may be Pregnant?* Yes ☐ No ☐
- Are you Nursing (breast feeding)? Yes ☐ No ☐
- Are you taking Birth Control Pills? Yes ☐ No ☐
- Do you have problems with your menstrual cycle? Yes ☐ No ☐
  - Or if pregnant, your pregnancy? Yes ☐ No ☐

If yes, please explain? _____

DENTAL HISTORY

Last Dental visit was _____ What was done? _____

ARE YOU IN PAIN NOW? Yes ☐ No ☐

If yes, please explain where it is, what it's like and for how long: _____

_____

Comments you would like to share with the Dentist or staff? _____

_____

_____

_____ _____

Patient Signature Date

_____ _____

Signature of Parent/Patient Representative Date