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

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

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**Please list what you are ALLERGIC to or have a REACTION to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

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**Comments you would like to share with the Dentist or staff?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Patient Signature Date

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Signature of Parent/Patient Representative Date

Reviewed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_