COLUMBUS DENTAL CARE, PLLC

Patient Health History Form

Patient Name: _____ Date of Birth: _____

Although dental personnel primarily treat the area in and around the mouth, your mouth is part of your entire body – health problems that you may have, or medications you are taking, could have an important connection with the dentistry you receive. Thank you for honestly answering the following questions.

Primary Care Physicians name/address/phone number:

Are there any concerns or changes you would like to make with your teeth?

If yes,_____

Do you need to premedicate prior to dental visits? No____ If yes, _____

Have you been hospitalized or had any surgery? No____ If yes, _____

_____

_____

Have you ever had a serious head or neck injury? No____ If yes, _____

Do you use tobacco? No____ If yes,_____

Do you take a daily aspirin? No_____ If yes,_____

Do you use controlled substances? No____ If yes,_____

Are you taking any medications or supplements? No_____ If yes, list all below:

PLEASE CIRCLE correct answer:

Pregnant/trying to conceive? Y or N - Are you nursing? Y or N - Taking Oral Contraceptives? Y or N

Are you allergic to any of the following?

-Aspirin? Y or N -Penicillin? Y or N -Codeine? Y or N -Sulfa Drugs? Y of N -Metal? Y or N

-Latex? Y or N -Acrylic? Y or N -Local Anesthetics? Y or N

Other allergies? No _____ Yes, explain: _____ Pg 1 of 2

Do you have, or have you had, any of the following? Please circle all that apply:

Acid Reflux
AIDS/HIV Positive
Alzheimer's Disease
Anemia
Angina
Anxiety
Arthritis
Artificial Heart Valve
Artificial Joint
Asthma
Autoimmune Disease
Behavior Disorder
Blood Disease
Cancer
Chemotherapy
Cold Sore
COPD
Depression
Diabetes
Emphysema
Epilepsy or seizures
Excessive Bleeding
Fainting/Dizzy Spells
Frequent Cough
Frequent Headaches
Glaucoma
Gout
Heart Attack
Heart Disease
Heart Murmur
Heart Pacemaker
Hepatitis
High Blood Pressure
High Cholesterol
Joint Pain
Kidney Problems
Leukemia
Liver Disease
Low Blood Pressure
Thyroid Disease
Lung Disease
Mitral Valve Prolapse
Osteoporosis
Pain in Jaw
Radiation Treatments
Rheumatic Fever
Sinus Trouble
Stomach/Intest-inal Disease
Stroke
Tonsilitis
Tuberculosis
Tumors or Growths
Ulcers
Venereal Disease

Do you have any other illness or condition NOT listed above? Yes No

If yes, _____

Comments:

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 (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status at each appointment.

Signature of Patient/Parent of Guardian:

x_____ Date: _____