DOVE FAMILY DENTISTRY

Family Dentistry with a Servant's Heart

Name ______________________________ **Today's Date**

Your answers on this form will help us provide you with our best possible care. **Thank you for your time.**

Date of Birth ______________ How would you rate your **general health**? __ Excellent __ Good __ Fair __ Poor

Physician Name ______________________________ City ________________ Phone # ________________

Medical Specialist Name ________________________ City ________________ Phone # ________________

Emergency Contact Name ________________________ Relationship ____________ Phone # ________________

List all **Surgeries**

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List Current Medications: prescription & over the counter

________________ for ________________

________________ for ________________

________________ for ________________

________________ for ________________

________________ for ________________

List all **Drug Allergies** and **Reactions**

__ Penicillin / Sulfa

__ Dental Anesthetic

__ Codeine

__ Aspirin / Advil

__ Latex

Others

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____

Review of Health: Please check any conditions that you may have had in the past or present.

__ Heart Disease
__ Heart Attack
__ High Blood Pressure
__ Heart Murmur
__ Mitral Valve Prolapse
__ High Cholesterol
__ Chest Pains
__ Pacemaker/ Defibrillator
__ Liver / Kidney Disease
__ Hepatitis A B C D E
__ Alcoholism
__ Cancer / Type ______________
__ Chemo or Radiation

__ Stroke / Seizure
__ Bleeding Disorder / Anemia
__ Thyroid Problems
__ Diabetes
__ Stomach Problem / Ulcer
__ Acid Reflux
__ Eating Disorder
__ Auto Immune Disease
__ Fibromyalgia
__ Osteoporosis
__ Arthritis
__ Herpes / STD's
__ HIV / AIDS

__ Asthma or Emphysema
__ Tuberculosis
__ Shortness of Breath
__ Parkinson's Disease
__ Multiple Sclerosis
__ Tobacco Use __ smoke __ chew
__ Developmental Disorder
__ Depression
__ ADD / ADHD
__ Dizziness / Fainting / Vertigo
__ Hearing / Vision Problems
__ Glaucoma
__ Artificial Joints / Pins

Have you ever taken any of the following medications:

__ Fosamax / Alendronate
__ Actonel / Risedronate
__ Etidronate
__ Tiludronate
__ Aredia / Pamidronate
__ Zometa / Zoledronate
__ Labandronate
__ Clodronate
__ Neridronate
__ Olpadronate

Any other disease or condition we should know about: ____

Have you ever needed to take an antibiotic prior to dental treatment ___ Yes ___ No

Women Only: Are you Pregnant? ___ Yes ___ No if Yes Expected due date ____________

Patient / Parent Signature: ______________________________

CLINICAL NOTES ONLY