NORTHWEST DENTAL GROUP, LLC / THE DENTAL OFFICE OF LINCOLN PARK – Confidential Health History

Name_____Age_____Date_____

Reason for visit : Circle all that apply:

Checkup and cleaning Cosmetic Dental Consultation Treatment Consultation Dental Implant consultation

Tooth problem (location)_____ Gum problem (location)_____

Describe problem_____

Other problem_____

LIST OF ALL MEDICATIONS (Include over-the-counter and supplements)

_____ _____ _____ _____

_____ _____ _____ _____

PREVIOUS MEDICATIONS:

Have you ever taken osteoporosis medications (such as Fosamax, Actonel, Atelvia, Didronel, Boniva): Yes No

Have you ever taken any of the group of drugs collectively known as fen-phen? (These include combinations of Ionimin, Adipex, FAstin, , Pondimin, and Redux) Yes No

REVIEW OF SYSTEMS: Circle if any of the following are your problems:

Cough
Double vision
Ear pain
Frequent infections
Irregular heart beat
Heart surgery
Heartburn
Muscle tone problems
Lump in thyroid
Shortness of breath
Swollen Neck glands
Prior blood transfusion
Weakened immune system
Weight Loss, unexplained

PAST MEDICAL HISTORY: Circle if any of the following are your problems:

Anemia
Arthritis/Rheumatism
Artificial Heart Valve
Anxiety/Depression
Articial Joints
Asthma
Back problems
Bleeding Abnormally
Blood disease
Cancer_____
Chemical Dependency
Chemotherapy
Circulatory Problems
Coronary artery disease
Diabetes, type I
Diabetes, type II
Emphysema/COPD
Epilepsy
Fainting/dizziness
Gastroesophageal reflux (GERD)
Glaucoma
Hayfever
Headache
Heart attack
Hepatitis
Herpes
HIV/AIDS
infection
High blood pressure
HPV infection
Hypotonia/low muscle tone
Irregular heart beat/arrhythmia
Kidney dialysis
Kidney disease
Leukemia
Low Blood Pressure
Migraines
Mitral valve prolapse
Nervous problems
Osteoporosis
Pacemaker
Radiation treatment
Respiratory disease
Sinus trouble
Sleep apnea
Psychiatric illness
Speech problems
Language delay
Stroke/CVA
Thyroid problems
Tonsilitiis
Transient ischemic attack/TIA
Tuberculosis
Ulcer (stomach)
Venerial disease
Vertigo

Any other medical conditions we should be aware of? _____

PAST DENTAL HISTORY: Circle if you have had any of the following:

Bad breath
Bleeding gums
Bridgework
Burning sensation on tongue
Canker sores
Clicking jaw
Dental Implants
Dentures/partials
Dry mouth
Fingernail biting
Food collection between teeth
Grinding teeth
Gum problems
Gum treatments
Jaw/TMJ pain
Mouth breathing
Orthodontic care
Salivary gland removal
Sensitive teeth
Sinus surgery
Wisdom tooth removal

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How often do you brush?_____ How often do you floss?_____

Any other dental issues or problems we should be aware of? _____

ALLERGIES: Please circle if you are allergic to the following: Penicillin Dental Anesthetics Codeine Sulfa Aspirin Latex

Please list any other allergies: _____

TOBBACO USE: Please circle your answer to the following questions:
Do you smoke cigarettes? NO YES, If YES on average,_____pack/day,_____years, OR quit in_____

Do you smoke cigars? NO YES, If YES on average,_____#/day, week,___years, OR quit in_____

Do you use chewing tobacco? NO YES, If YES on average,_____times/day,____years, OR quit in_____

I certify the above Confidential Health History is correct to the best of my knowledge. I will not hold my doctor or his/her associates responsible for any errors or omissions that I have made in completion of this form. I will inform my doctor of any changes that occur.

_____	_____	_____	_____	_____	_____
Patient/Parent Signature	Date	Reviewed by	Date	Entered by	Date

Rev 5/1/2014