HAVEN DENTAL

Health History

Although we primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Name: _____ Date of Birth _____

Date of last MEDICAL exam: _____ Preferred Pharmacy: _____

Please list name and phone number of the physicians who are currently providing you care:

_____ _____ _____

_____ _____ _____

Hospitalizations and major operations:

_____ _____ _____

_____ _____ _____

Do you take antibiotics prior to dental appointments? Y N If yes, what antibiotic? _____

Please list all medications/supplements you are taking: (*if you have a physical list we can make a copy*)

_____

_____

_____

Please list any allergies: _____

_____

For the following questions CIRCLE yes or no. Our team may ask additional questions based upon your responses.

Cardiovascular Disease	Y	N	Sinus Trouble	Y	N	Cancer	Y	N
Angina/Chest Pain	Y	N	Asthma	Y	N	Chemotherapy	Y	N
Arteriosclerosis	Y	N	Emphysema	Y	N	Radiation Treatment	Y	N
Congestive Heart Failure	Y	N	COPD	Y	N	Osteoporosis	Y	N
Heart Attack	Y	N	Tuberculosis	Y	N	Tobacco use	Y	N
High Blood Pressure	Y	N	Diabetes	Y	N	Gag Reflex	Y	N
Low Blood Pressure	Y	N	Eating Disorder	Y	N	Nasal Congestion	Y	N
Pacemaker	Y	N	Gastrointestinal Disease	Y	N	Autism	Y	N
Heart Stent	Y	N	Acid Reflux	Y	N	ADHD/ADD	Y	N
Artificial Heart Valve	Y	N	Ulcers	Y	N	Alzheimer's/Dementia	Y	N
Previous Bacterial Endocarditis	Y	N	Thyroid Disorder	Y	N	Mental Health Disorder	Y	N
Congenital Heart Disease	Y	N	Stroke	Y	N	Psychiatric Treatment	Y	N
Anemia	Y	N	Glaucoma	Y	N	Neurological Disorder	Y	N
Blood disorders/Abnormal bleeding	Y	N	Hepatitis/Jaundice/ Liver Disease	Y	N	Sleep Disorder	Y	N
Hemophilia	Y	N	Kidney Disease	Y	N	Anaphylaxis	Y	N
Autoimmune Disease	Y	N	Renal Dialysis	Y	N	Drug Abuse/Addiction	Y	N
Arthritis/Gout	Y	N	Epilepsy/Seizures	Y	N	Bruise Easily	Y	N
AIDS/HIV+	Y	N	Fainting/Dizziness	Y	N	Chronic Pain	Y	N
Pregnant	Y	N	Venereal Disease/STD	Y	N	Headaches/Migraines	Y	N
Nursing	Y	N	Joint Replacement	Y	N	Other	Y	N

Patient Signature: _____ Date: _____