JORDANview DENTAL

Patient Name:_____ Date: _____

HEALTH HISTORY

- ☐ AIDS
- ☐ ALLERGIES_____
- ☐ ANEMIA
- ☐ ARTHRITIS
- ☐ ARTIFICIAL JOINTS
- ☐ ASTHMA
- ☐ BIPHOSPHONATE THERAPY
- ☐ BLOOD DISEASE
- ☐ CANCER _____
- ☐ DIABETES - type _____
- ☐ DIZZINESS
- ☐ EPILEPSY
- ☐ EXCESSIVE BLEEDING
- ☐ FAINTING
- ☐ GLAUCOMA
- ☐ GROWTHS
- ☐ HAY FEVER
- ☐ HEART DISEASE
- ☐ HEART MURMUR ☐pre-med.
- ☐ HEPATITS ☐A ☐B ☐C
- ☐ HIGH BLOOD PRESSURE
- ☐ KIDNEY DISEASE
- ☐ LIVER DISEASE
- ☐ MENTAL DISORDERS
- ☐ NERVOUS DISORDERS
- ☐ PACEMAKER
- ☐ PHEN-PHEN (Have taken)
- ☐ PREGNANCY (CURRENT)

DUE DATE: _____

- ☐ RADIATION TREATMENT
- ☐ RESPIRATORY PROBLEMS
- ☐ RHEUMATIC FEVER
- ☐ RHEUMATISM
- ☐ SINUS PROBLEMS
- ☐ STOMACH PROBLEMS
- ☐ STROKE
- ☐ TOBACCO USE
- ☐ TUBERCULOSIS
- ☐ TUMORS
- ☐ ULCERS
- ☐ VENEREAL DISEASE
- ☐ CODEINE ALLERGY
- ☐ PENICILLIN ALLERGY
- ☐ SULFA ALLERGY

OTHER_____

Medications

Date of Last Cleaning: _____

1 Have you ever had any complications following dental treatment? ☐Y ☐N _____

_____

2 Have you been admitted to a hospital or needed emergency care during the past 2 years? ☐Y ☐ N _____

_____

3 Are you under the care of a physician? ☐ Y ☐N _____

4 Name of Physician_____ Phone_____

5 Do you have any health problems that need further clarification? _____

_____

6 Reason for today's visit: ☐ Cleaning & Checkup ☐Other: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform Dr. Frank at the next appointment without fail.

X _____ Date:_____

Date	EXCEPTIONS		PATIENT SIGNATURE	REVIEWED BY:
_____	_____	NONE	_____	_____
_____	_____	NONE	_____	_____
_____	_____	NONE	_____	_____
_____	_____	NONE	_____	_____
_____	_____	NONE	_____	_____
_____	_____	NONE	_____	_____
_____	_____	NONE	_____	_____