MAPLE STREET DENTAL CLINIC **109 E. Maple, Gillespie, Il. 62033**

PATIENT HEALTH HISTORY

Last Name: _____ First Name: _____ M I: _____ Today's Date: _____

Birth Date: _____ Sex: M / F

If the patient is a minor, please provide the parent's/ guardian's name: _____

MEDICAL HISTORY:

Do you have a medical doctor? Y N

Medical Doctor's name and phone number: _____

Please list all medications you are currently taking:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Have you ever taken or are you currently taking a Bisphosphonate drug such as Zometa, Fosamax, Actonel, Boniva or Aredia? Y N If yes, What drug? _____

Y	N	High Blood Pressure	Y	N	Herpes/Fever Blisters	Y	N	Epilepsy/Seizures
Y	N	Low Blood Pressure	Y	N	HIV+/AIDS	Y	N	Migraines/Headaches
Y	N	Pacemaker	Y	N	Hepatitis	Y	N	Fainting/ Dizzy spells
Y	N	Mitral Valve Prolapse	Y	N	Liver Disease	Y	N	Sinus Problems
Y	N	Heart Attack	Y	N	Kidney Problems	Y	N	Psychiatric Conditions
Y	N	Heart Surgery	Y	N	Diabetes	Y	N	Difficulty Breathing
Y	N	Heart Murmur	Y	N	Ulcers/Colitis	Y	N	Tuberculosis or +PPD
Y	N	Congenital Heart Defect	Y	N	Arthritis	Y	N	Asthma
Y	N	Anemia	Y	N	Artificial Joints/Valves	Y	N	Emphysema
Y	N	Bleeding Problems	Y	N	Cancer	Y	N	Stroke
Y	N	Bruise Easliy	Y	N	Chemotherapy	Other conditions not listed:		
Y	N	Sickle Cell Anemia	Y	N	Radiation Treatment	_____		
Y	N	Hemophilia	Y	N	Hospitalized for any reason	_____		

Y N Tobacco use? If yes, how many packs a day? _____ How many years? _____

Y N Alcohol Use? If yes, how many drinks per week? _____

Y N Drug Abuse? If yes, what drugs? _____

FOR WOMEN: Are you pregnant? Y N If yes, what is your due date? _____

Are you nursing? Y N

ALLERGIES:

Are you allergic to any of the following: Y / N

Dental Anesthetics	Penicillin	Codeine	Latex	Other:
Aspirin	Amoxicillin	Erythromycin	Metals	_____

DENTAL HISTORY:

What is the reason for your visit today? _____ When was your last dental examination? _____

PATIENT AUTHORIZATION/ CONSENT TO TREATMENT:

The information I have provided is correct to the best of my knowledge. I assume any risk to myself or my ward, and understand that I will ask if there are any questions regarding diagnosis or treatment. I understand it is my responsibility to inform this office of any changes in my/my ward's medical status and/or medications being taken. I authorize treatment, the use of nitrous oxide, anesthesia, oral sedation and/or other medications necessary to be rendered by the staff. I understand that I will be expected to update the information on this History form on an annual basis.

Patient's Signature: _____ Date: _____

Provider's Signature: ____ Date: _________________________