OLIN DENTAL GROUP
PATIENT HEALTH HISTORY

PATIENT NAME_______________________________________ DATE OF BIRTH______________________
PHYSICIAN NAME____________________________________ PHYSICIAN'S SPECIALTY________________
PHYSICIAN'S TOWN/CITY______________________________ PHYSICIAN'S PHONE __________________
PHARMACY ________________________________ PHARMACY LOCATION ____________________________
PHARMACY PHONE ________________________________

DENTAL HISTORY:

- Former Dentist___________________________________ Date of Last X-rays_________________
- Location of Former Dentist ____
- ***Have you ever experienced a reaction to local anesthesia***? Y / N
- ***Have you ever bled excessively from an extraction or dental procedure?*** Y / N
- ***Have you ever had head or neck trauma?*** Y / N
- ***Have you ever had TMJ or jaw problems?*** Y / N
- ***Have you ever worn an occlusal (night) guard?*** Y / N
- ***Are you happy with the look of your teeth?*** Y / N
- ***Do you want cosmetic dentistry to change the look of your teeth?*** Y / N
- ***Are you interesting in whitening (bleaching) your teeth?*** Y / N
- ***Do you want your teeth straightened (orthodontics)?*** Y / N
- ***Do you smoke?*** Y / N ***Do you chew tobacco?*** Y / N
- ***Do you overuse alcohol?*** Y / N ***Do you use recreational drugs?*** Y / N

PLEASE CHECK ALL THAT APPLY:

__Bad Breath	__Loose Teeth or Broken Fillings	__Sweet Sensitivity
__Bleeding Gums	__Orthodontic Treatment	__Pain to Biting
__Mouth or Lip Blisters	__Pain Around the Ear	__Frequent Headaches
__Finger Nail Biting	__Periodontal Treatment	__Jaw Clicking or Pain
__Grinding Teeth	__Sensitivity to Cold or Hot	__Tooth Pain

MEDICAL HISTORY:

- ***Are you in good health?*** Y / N
- ***Have you had any serious medical condition that caused you to be hospitalized?*** Y / N
- ***Have you had any serious operations?*** Y / N
- ***Have you had any complications to previous surgeries?*** Y / N. If yes, what happened? ______
  ____
- ***Have there been any changes in your general health the past year?*** Y / N
- ***Are you under the care of a physician?*** Y / N. If yes, what are you being treated for:
  ____
- ***Date of your last general medical physical***? Date: ___________________
- ***Do you have any artificial stent, vascular graft, heart valve, joint or prosthesis in your body***? Y / N. If yes, detail it ____
- ***Do you have a communicable disease such as HIV+, AIDS, Tuberculosis, and Hepatitis as examples?*** *Your answers will be held in total confidence and there will never* be any unwarranted negative action taken. We never discriminate in this office. Y / N

HAVE YOU HAD ANY ALLERGIC REACTIONS TO THE FOLLOWING?

Local anesthetic	Y / N
Epinephrine (adrenaline)	Y / N
Penicillin (Amoxicillin)	Y / N
Erythromycin (Biaxin)	Y / N
Clindamycin	Y / N
Sulfa	Y / N
Other Antibiotics	Y / N List which ones ________________________________
Tranquilizers, Valium, Barbituates	Y / N
Aspirin	Y / N
Ibuprofen (Advil, Motrin)	Y / N
Codeine & other narcotics	Y / N
Iodine (IV dyes)	Y / N
Latex (Rubber)	Y / N

List any other drug allergies: ____

I do not have any allergies to medicines ____

HAVE YOU HAD OR DO YOU CURRENTLY HAVE (Please check):

__AIDS
__Anemia
__Arthritis
__Artificial Heart Valve
__Artificial Heart Valves
__Artificial Joints
__Arterial Shunts or Stents
__Asthma
__Back Problems
__Bleeding Abnormally
__Blood Disease
__Cancer
__Chemical Dependency
__Chemotherapy
__Chest Pain/Angina
__Chronic Fatigue Syndrome
__Circulatory Problems
__Convulsions
__Cortisone Treatments
__Cough-persistent or bloody
__Defibrillator
__Diabetes
__Dialysis
__Emphysema
__Epilepsy
__Fainting or Dizziness
__Glaucoma

__Headaches
__Heart Attack
__ Heart Murmur
__Heart Valve Problem
__Heart-Irregular Beat
__Heart Surgery
__Hepatitis-Type____
__Herpes-Type____
__High Blood Pressure
__High Cholesterol
__HIV Positive
__Immune Suppressed
__Jaundice
__Jaw Pain
__Kidney Disease
__Latex Sensitivity
__Liver Disease
__Low Blood Pressure
__Malignant Hyperthermia
__Mitral Valve Prolapse
__Mononucleosis
__Nervous Problems
__Pacemaker
__Pregnant
__Psychiatric Care
__Radiation Treatment
__Respiratory Treatment
__Rheumatic Fever

__Rheumatic Heart Disease
__Scarlet Fever-Heart Disease
__Stents-Heart/Brain
__Shortness of Breath
__Sickle Cell Anemia
__Sinus Trouble
__Stroke
__Snoring/Sleep Apnea
__Stomach Ulcers/Acid Reflux
__Swelling of Feet/Ankles
__Swollen Neck Glands
__Thyroid Gland Problems
__Tonsillitis
__Tuberculosis
__Tumor on Head/Neck
__Ulcers
__Venereal Disease
__Xerostomia (Dry Mouth)
__Other (List Below)
__PREMEDICATION NECESSARY

____

WOMAN ONLY:

Are you possibly pregnant? Y/N

# of weeks pregnant? _______

Taking Birth Control? Y / N

Are you nursing? Y / N

PATIENTS WHO HAVE OR HAD CANCER: (If yes, answer the following)

Is your cancer active or in remission? _________________

What type of cancer? _____________________________

Have you had chemotherapy? Y / N

Have you had radiation therapy? Y / N

MEDICATIONS:

***Are you taking any kind of prescription medicine*?** Y / N

If yes, please list the medications below.

Are you taking any kind of diet pill? Y / N

If yes, please list the medications below.

Are you taking blood thinners such as Aspirin, Coumadin, Warfarin, Plavix, Vitamin E, or Ginko Biloba? Y / N

If yes, list the medications below.

Are you taking medicines that are considered bone density builders called Bisphosphonates such as Actonel, Zometa, Fosamax, Boniva, and Aredia? Y / N

If yes, list the medication below.

Are you taking pain relievers either over the counter or prescription? Y / N

If yes, list the medications below.

LIST ALL OF THE MEDICATIONS THAT YOU ARE TAKING AT THIS TIME:

List Current Medications (Rx)	Update	Update	Update	Update
______________________________				
______________________________	Update	Update	Update	Update
______________________________				
______________________________	Update	Update	Update	Update
______________________________				
______________________________	Update	Update	Update	Update
______________________________				
______________________________	Update	Update	Update	Update
______________________________				

	Changes to Medications (Dentist to Complete)
______________________________	
______________________________	____
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