PATIENT HEALTH HISTORY

Your Name: _____ **Date of Birth:** _____

Physician's Name: _____ **Physician's Phone:** _____ **Medical/Kaiser #:** _____

Although dental personnel 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 medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ..... O Yes O No _____
Have you ever been hospitalized or had a major operation? ..... O Yes O No _____
Have you ever had a serious head or neck injury? ..... O Yes O No _____
Are you taking any medications, pills, or drugs? (please list)..... O Yes O No _____
Do you take, or have taken Phen-Fen or Redux? ..... O Yes O No _____
Do you take, or have ever taken Fosamax or any other Bisphosphonates, if so for how long?..... O Yes ONo _____
Are you on a special diet? ..... O Yes O No _____
Do you use tobacco? ..... O Yes O No _____
Do you use controlled substances? ..... O Yes O No _____
Do you need to be pre-medicated with antibiotics prior to dental treatment? ..... O Yes O No _____
Are you currently taking any blood thinner medication? ..... O Yes O No _____
Are you currently wearing a pacemaker? ..... O Yes O No _____
Are you able to eat and chew foods satisfactorily? ..... O Yes O No _____
Are you experiencing any dental/gum pain or discomfort at this time? ..... O Yes O No _____
Are you aware of any clenching or grinding of your teeth? ..... O Yes O No _____
Have you ever had any periodontal treatment, such as deep cleaning/root planning or surgery? ..... O Yes O No _____

Women: Are you?

Pregnant/Trying to get pregnant? ..... O Yes O No _____
Nursing? ..... O Yes O No _____
Taking oral contraceptives? ..... O Yes O No _____

Are you allergic to or have had any reactions to the following?

Yes ☐ No ☐ Amoxicillin
Yes ☐ No ☐ Aspirin
Yes ☐ No ☐ Augmentin
Yes ☐ No ☐ Barbiturates
Yes ☐ No ☐ Cleocin
Yes ☐ No ☐ Codeine
Yes ☐ No ☐ Epinephrine
Yes ☐ No ☐ Erythromycin
Yes ☐ No ☐ Flagyl
Yes ☐ No ☐ Ibuprofen
Yes ☐ No ☐ Iodine
Yes ☐ No ☐ Latex
Yes ☐ No ☐ Local Anesthetics
Yes ☐ No ☐ Penicillin
Yes ☐ No ☐ Sedatives
Yes ☐ No ☐ Sulfa Drugs
Yes ☐ No ☐ Tetracycline
Yes ☐ No ☐ Tylenol
Yes ☐ No ☐ Vicodin
Yes ☐ No ☐ Zithromax
Yes ☐ No ☐ Other _____

Do you have or have you had any of the following?

Yes ☐ No ☐ AIDS/HIV
Yes ☐ No ☐ Alzheimer's Disease
Yes ☐ No ☐ Anaphylaxis
Yes ☐ No ☐ Anemia
Yes ☐ No ☐ Angina
Yes ☐ No ☐ Arthritis
Yes ☐ No ☐ Artificial Heart Valve
Yes ☐ No ☐ Artificial Joint
Yes ☐ No ☐ Asthma
Yes ☐ No ☐ Blood Disorder
Yes ☐ No ☐ Blood Transfusion
Yes ☐ No ☐ Bruise Easily
Yes ☐ No ☐ Cancer
Yes ☐ No ☐ Chemotherapy
Yes ☐ No ☐ Chest Pains
Yes ☐ No ☐ Cold Sores/Fever Blisters
Yes ☐ No ☐ Congenital Heart Disorder
Yes ☐ No ☐ Cortisone Medicine
Yes ☐ No ☐ Convulsions
Yes ☐ No ☐ Diabetes
Yes ☐ No ☐ Drug Addiction
Yes ☐ No ☐ Emphysema
Yes ☐ No ☐ Epilepsy or Seizures
Yes ☐ No ☐ Excessive Bleeding
Yes ☐ No ☐ Fainting Spells/Dizziness
Yes ☐ No ☐ Frequent Cough
Yes ☐ No ☐ Frequent Headaches
Yes ☐ No ☐ Genital Herpes
Yes ☐ No ☐ Glaucoma
Yes ☐ No ☐ Hay Fever/Allergies
Yes ☐ No ☐ Heart Attack/Failure
Yes ☐ No ☐ Heart Murmur
Yes ☐ No ☐ Heart/Cardiac Pacemaker
Yes ☐ No ☐ Heart Trouble/Disease
Yes ☐ No ☐ Hemophilia
Yes ☐ No ☐ Hepatitis A
Yes ☐ No ☐ Hepatitis B or C
Yes ☐ No ☐ Herpes
Yes ☐ No ☐ High Blood Pressure
Yes ☐ No ☐ Hives or Rash
Yes ☐ No ☐ Hypoglycemia
Yes ☐ No ☐ Irregular Heartbeat
Yes ☐ No ☐ Jaundice
Yes ☐ No ☐ Kidney Problems
Yes ☐ No ☐ Leukemia
Yes ☐ No ☐ Liver Disease
Yes ☐ No ☐ Low Blood Pressure
Yes ☐ No ☐ Lung Disease
Yes ☐ No ☐ Mitral Valve Prolapse
Yes ☐ No ☐ Pain in Jaw Joints
Yes ☐ No ☐ Parathyroid Disease
Yes ☐ No ☐ Psychiatric Care
Yes ☐ No ☐ Radiation Treatment
Yes ☐ No ☐ Recent Weight Loss
Yes ☐ No ☐ Renal Dialysis
Yes ☐ No ☐ Respiratory trouble
Yes ☐ No ☐ Rheumatic Fever
Yes ☐ No ☐ Rheumatism
Yes ☐ No ☐ Scarlet Fever
Yes ☐ No ☐ Shingles
Yes ☐ No ☐ Sickle Cell Disease
Yes ☐ No ☐ Sinus Trouble
Yes ☐ No ☐ Spina Bifida
Yes ☐ No ☐ Stomach/Intestinal Disease
Yes ☐ No ☐ Stroke
Yes ☐ No ☐ Swelling of Limbs
Yes ☐ No ☐ Thyroid Trouble
Yes ☐ No ☐ Tonsillitis
Yes ☐ No ☐ Tuberculosis
Yes ☐ No ☐ Tumors or Growths
Yes ☐ No ☐ Ulcers
Yes ☐ No ☐ Venereal Disease
Yes ☐ No ☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ..... O Yes O No _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____
Signature of Patient, Parent, or Guardian **Date**

_____ _____
Signature of Treating Doctor **Date**

`NICKY M. HAKIMI, D.D.S., M.S.D.
212 Lincoln Way ◆ Auburn, CA 95603
Telephone (530) 888-7155 ◆ Fax (530) 888-7197 ◆ Visit us at: www.periozone.com

HEALTH HISTORY UPDATE

(office use only)

Date: ______________________

Health Changes: ______________________________

____

____

____

Current Medications: ______________________________

____

____

____

Physician's Name: ______________________________

Physician's Phone: ______________________________

Patient's Signature: ______________________________

Last Physical Exam: ______________________________

Allergies: ______________________________

Staff Initials: ______________________________

Date: ______________________

Health Changes: ______________________________

____

____

____

Current Medications: ______________________________

____

____

____

Physician's Name: ______________________________

Physician's Phone: ______________________________

Patient's Signature: ______________________________

Last Physical Exam: ______________________________

Allergies: ______________________________

Staff Initials: ______________________________

Date: ______________________

Health Changes: ______________________________

____

____

____

Current Medications: ______________________________

____

____

____

Physician's Name: ______________________________

Physician's Phone: ______________________________

Patient's Signature: ______________________________

Last Physical Exam: ______________________________

Allergies: ______________________________

Staff Initials: ______________________________

Date: ______________________

Health Changes: ______________________________

____

____

____

Current Medications: ______________________________

____

____

____

Physician's Name: ______________________________

Physician's Phone: ______________________________

Patient's Signature: ______________________________

Last Physical Exam: ______________________________

Allergies: ______________________________

Staff Initials: ______________________________
