MOUNTAIN VIEW DENTAL CARE
HEALTH HISTORY INFORMATION

PATIENT NAME _____ **DATE** _____

Please complete this entire questionnaire. This will provide your care team with important information about your health. All answers are strictly confidential. Any changes from previous visits will be made in your medical record.

MEDICATIONS

Please list any medications you are currently taking _____

_____

Approximate date of last dental cleaning _____Are you currently pregnant or nursing? _____

Tobacco use? If so, what kind and how much? _____

Any unusual reactions to dental injections? _____

Please list any current surgeries (within last 5 yrs.) _____

Do you have any apprehension concerning dental treatment? ☐ Mild ☐ Moderate ☐ Severe

ALLERGIES

Are you allergic to any of the following?

- ☐ Acetaminophen (Tylenol)
- ☐ Anesthetic (Dental)
- ☐ Aspirin
- ☐ Clindamycin
- ☐ Codeine
- ☐ Epinephrine
- ☐ Erythromycin
- ☐ Ibuprofen
- ☐ Iodine
- ☐ Latex
- ☐ Penicillin
- ☐ Sedatives
- ☐ Sulfa
- ☐ Tetracycline
- ☐ No known allergies

Other _____

MEDICAL CONDITIONS

Do you have any of the following medical conditions?

- ☐ Abnormal Bleeding
- ☐ Acid Reflux-Gerd
- ☐ ADHD
- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Cold Sores
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Glaucoma
- ☐ Hearing Aids
- ☐ Hearing Problems
- ☐ Heart Attack
- ☐ Heart Mitral Valve Replacement/Repair
- ☐ Heart Surgery
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV Positive/AIDS
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Migraines
- ☐ Nose Bleeds (Frequent)
- ☐ Osteoporosis
- ☐ Psychiatric Treatment
- ☐ Radiation Treatment
- ☐ Sexually Transmitted Disease
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Emphysema/COPD

Other _____

To the best of my knowledge, all of the answers on this form are true and correct. If I ever have any change in my health, I will inform the doctor and/or hygienist at my next appointment.

SIGNATURE _____ DATE_____

Reviewed by _____ *Date* _____