



PIKE DENTISTRY

Cosmetic & General Dentistry

HEALTH HISTORY INFORMATION

PATIENT NAME: _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? PLEASE CHECK YES OR NO TO EACH :

YES	NO		YES	NO	
___	___	ANGINA (CHEST PAINS)	___	___	HIV / AIDS AUTOIMMUNE DISORDER
___	___	HEART ATTACK / STROKE (YR: _____)	___	___	VENEREAL DISEASE / HERPES
___	___	HEART VALVE REPLACE / STENT PLACED	___	___	IMMUNE DEFICIENCY
___	___	HEART MURMUR	___	___	TUMOR / MALIGNANCY
___	___	MITRAL VALVE PROLAPSE	___	___	RADIATION / CHEMOTHERAPY
___	___	PACEMAKER / DEFIBRILLATOR	___	___	CANCER
___	___	CONGENITAL HEART LESIONS	___	___	THYROID PROBLEMS
___	___	HIGH / LOW BLOOD PRESSURE	___	___	ARTHRITIS / RHEUMATISM
___	___	RHEUMATIC / SCARLET FEVER	___	___	CIGARETTE / PIPE / CIGAR / DIP USAGE
___	___	SHUNT PLACED	___	___	HEADACHES
___	___	HIP / KNEE / JOINT REPLACEMENT	___	___	JAW PAIN / JAW TIREDNESS
___	___	ARE YOU TAKING BLOOD THINNER MEDICATIONS?	___	___	GRINDING / CLENCHING TEETH
___	___	BLEEDING PROBLEMS	___	___	CLICKING / POPPING OF JAW
___	___	CIRCULATORY PROBLEMS	___	___	LOOSE TEETH / BROKEN FILLINGS
___	___	LIVER PROBLEMS	___	___	TOOTH SENSITIVITY: COLD / HEAT / SWEETS
___	___	HEPATITIS A / B / C	___	___	DRY MOUTH / MOUTH BREATHING
___	___	DIABETES	___	___	GUMS SWOLLEN / TENDER / BLEEDING
___	___	TAKING INSULIN	___	___	BAD BREATH
___	___	KIDNEY PROBLEMS	___	___	CHEMICAL DEPENDENCY
___	___	ORGAN TRANSPLANT	___	___	ARE YOU TAKING MEDICATION FOR OSTEOPOROSIS?
___	___	RESPIRATORY PROBLEMS	___	___	ALLERGIES (Please List All)
___	___	ASTHMA / EMPHYSEMA			_____
___	___	TUBERCULOSIS			_____
___	___	EPILEPSY / SEIZURES			_____
___	___	PSYCHIATRIC CARE / NERVOUS PROBLEMS			_____

DATE: _____

Signature of Patient, Parent, Guardian or Personal Representative

UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment Yes ___ No ___

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Signature of Patient, Parent, Guardian or Personal Representative

Doctor's Signature

UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment Yes ___ No ___

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Signature of Patient, Parent, Guardian or Personal Representative

Doctor's Signature