desertpearl DENTISTRY

WELCOME to Desert Pearl Dentistry!

DENTAL HEALTH HISTORY

What is the reason for your visit today?_____

How would you rate your current dental health? ☐ Good ☐ Fair ☐ Poor

Do you have anxiety or fear about visiting a dentist and/or receiving dental treatment? ☐ Yes ☐ No

MEDICAL HEALTH HISTORY

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

YES NO

☐ ☐ Cancer or tumor
☐ ☐ Heart ailment or angina
☐ ☐ Heart murmur, mitral valve prolapse, heart defect
☐ ☐ Rheumatic fever or rheumatic heart disease
☐ ☐ Artificial heart valve
☐ ☐ Artificial joint (i.e. knee or hip replacement)
☐ ☐ High or low blood pressure
☐ ☐ Pacemaker
☐ ☐ Anemia or blood disorders
☐ ☐ Abnormal bleeding after extractions, surgery, or trauma
☐ ☐ Tuberculosis or other lung problems
☐ ☐ Kidney disease
☐ ☐ Hepatitis or other liver disease
☐ ☐ Alcoholism
☐ ☐ Drug abuse or addiction
☐ ☐ Diabetes
☐ ☐ Stroke / TIA / or neurologic condition
☐ ☐ Epilepsy, seizures, or fainting spells
☐ ☐ Emotional condition
☐ ☐ Arthritis
☐ ☐ Herpes or cold sores
☐ ☐ AIDS or HIV positive
☐ ☐ Asthma

Do you smoke or use chewing tobacco? ☐ Yes ☐ No

If yes, how often each day?_____

Are you ALLERGIC to, or have you reacted adversely to any of the following?

YES NO

☐ ☐ Latex materials
☐ ☐ Penicillin or other antibiotics:_____
☐ ☐ Local anesthetics ("Novocaine")
☐ ☐ Codeine or other narcotics
☐ ☐ Sulfa drugs
☐ ☐ Barbiturates, sedatives, or sleeping pills
☐ ☐ Aspirin
☐ ☐ Other:_____

_____

Are you TAKING any of the following?

☐ ☐ Aspirin
☐ ☐ Anticoagulants (blood thinners)
☐ ☐ Antibiotics or sulfa drugs
☐ ☐ High blood pressure medicine
☐ ☐ Antidepressants
☐ ☐ Insulin / Metformin (diabetes meds)
☐ ☐ Nitroglycerin
☐ ☐ Cortisone or other steroids
☐ ☐ Osteoporosis (bone density) medicine such as: Actonel, Boniva, Fosamax, etc.
☐ Other:_____

_____

_____

Women:

Are you or could you be pregnant? ☐ Yes ☐ No

If yes, for how long?_____

Are you currently nursing? ☐ Yes ☐ No

Are you currently on birth control? ☐ Yes ☐ No

I understand that any information that I have provided, including but not limited to my personal information, my dental and medical health history, is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence. It is my responsibility to inform this office of any changes in my personal information, medical status, or insurance information.

Patient Signature (Parent signs for minor):_____ Date:_____

BP:_____ Date:_____ BP:_____ Date:_____ BP:_____ Date:_____

Notes:

Dr. Signature:_____ Date:_____