Chesterfield Dentist

HEALTH HISTORY for Dr. Milan Bhagat and david r beam

PATIENT NAME: ____________________________

BIRTH DATE: ____________________________

DATE CREATED: ____________________________

PRIMARY PHYSICIAN/ALLERGY QUESTIONS

Name of your primary care physician ______________________________________ Primary care physician's telephone number ________________________________ Date of your last physical exam ____

Are you allergic to any of the items listed below:

Penicillin	_ Yes	_ No	Latex	_ Yes	_ No	Synthetic Dyes, flavoring	_ Yes	_ No
Codeine	_ Yes	_ No	Acrylic	_ Yes	_No	Aspirin	_ Yes	_ No
Local Anesthetics	_ Yes	_ No	Metals	_ Yes	_ No	Sulfa	_Yes	_ No

IMPORTANT HEALTH INFORMATION

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.

Are you under a physician's care now? If so, why? _ Yes _No
If yes, ____

Have you ever had a serious head or neck injury? _Yes_ No
If yes, ____

Are you currently taking any medications, please list name of drug, strength and dosage amount. _Yes _ No
If yes, ____
____
____

Have you currently or in the past abused street/illegal or prescription drugs? If yes, please tell us which drug. _ Yes _ No
If yes, ____

Do you drink alcohol? How often do you drink? _ Yes _ No
If yes, ____

Have you ever been in a Treatment Program for Alcohol or Drugs? If so, when? _ Yes _ No
If yes, ____

WOMEN ONLY

Pregnant _ Yes _ No Trying to become pregnant _ Yes _ No Breastfeeding _ Yes _No

Do you use tobacco products? If so, do you smoke cigarettes, cigars, pipes, use chewing tobacco, or dip?
What frequency? _ Yes _ No If yes, ____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? _Yes _No
If yes, ____

Are you on a special diet? _ Yes _ No If yes, ____

MEDICAL HISTORY

CARDIOVASCULAR

Heart Attack	_ Yes	_ No	Heart Transplant	_Yes	_ No	Low Blood Pressure	_ Yes	_No
Cardiac Stents	_ Yes	_ No	Mitral Valve Prolapse	_ Yes	- No	Heart Palpitations	_ Yes	_ No
Heart Murmur	_ Yes	_No	Artificial Heart Valve	_ Yes	_No	Heart Fibrillation	_ Yes	_ No
Heart Bypass	_ Yes	_ No	Angina/Chest Pain	_ Yes	_No	Heart Surgery	_ Yes	-No
Congestive Heart Failure	_ Yes	_ No	**Rheumatic Fever**	- Yes	- No	Congenital Heart Disorder	_ Yes	-No
Pacemaker	_ Yes	_ No	High Blood Pressure	_ Yes	_ No	Heart Regurgitation	_ Yes	_ No

BLOOD DISORDERS

High Cholesterol	_ Yes	_ No	Blood Transfusions	_ Yes	_ No	Hemophilia	_Yes	_No

Bleeding Problems	_ Yes	_ No	**AIDS/HIV**	_Yes	_No
Chronic Anemia	_ Yes	_ No	Sickle Cell Disease	_ Yes	_ No

SYSTEMIC DISORDERS/CANCER

Osteoporosis	_ Yes	_ No	Chemotherapy	_ Yes	_ No	Acid Reflux	_ Yes	_No
Neurologic Conditions	_Yes	_No	Kidney Problems	_ Yes	_ No	Epilepsy	_Yes	_ No
Cancer	_ Yes	_ No	Ulcers	_ Yes	_ No	Hypo/Hyperthyroidism	_Yes	_ No
Yellow Jaundice	_Yes	_ No	Multiple Sclerosis	_Yes	_ No	Radiation Treatments	_Yes	_ No
Stomach/Intestinal Disease	_ Yes	_ No	Seizures	_Yes	_ No	Renal Dialysis	_ Yes	_ No
Hepatitis A	_Yes	_ No	Goiter	_ Yes	_ No	Hypoglycemia	_Yes	_ No
Hepatitis B or C	_ Yes	_ No	Leukemia	_ Yes	_ No	Herpes	_Yes	_ No
Lupus	_ Yes	_ No	Liver Disease	_Yes	- No	Fibromyalgia	_Yes	_ No
Stroke - Any	_ Yes	_ No	Glaucoma	_Yes	_No			
Diabetes	_ Yes	_ No	Cold Sores - Fever Blisters	_ Yes	_ No			

If you answered yes to the cancer questions, please tell us what type of cancer and year you were diagnosed.
____

RESPIRATORY

Asthma	_ Yes	- No	COPD	_ Yes	_No	TB	_Yes	_No
Emphysema	_ Yes	_No						

ORTHOPAEDIC CONDITIONS

Arthritis/Gout	_ Yes	_ No	Artificial Joint	_ Yes	_ No	Joint Replacement	_Yes	_ No
TMJ	_Yes	_No	Plates, Pins or Screws	_ Yes	_ No	Hip Replacement	_Yes	_ No

Have you been advised to take an antibiotic prior to dental treatment? Which doctor prescribed and what was prescribed? _ Yes _ No If yes,
____

Have you had any other serious illnesses, surgeries or medical issues not listed? If so, please explain._ Yes _ No If yes,
____

Have you traveled outside of the U.S. in the last 12 months? If so, where?
_Yes _No If yes, ____

SIGNATURE

____ ______________________

Signature of Patient, Parent or Guardian Date

Sig **FOR DOCTOR'S USE** Medical History Reviewed By ____________________ Blood Pressure Reading __________ Commrnt: ___________________________