

# Health History

## Chesterfield Dentist

Dr. Milan Bhagat & Dr. Leigh Blakiston

**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
<b>Heart Murmur</b>	_ 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	<b>Rheumatic Fever</b>	_ Yes	_ No	Congenital Heart Disorder	_ Yes	_ No
Pacemaker	_ Yes	_ No	High Blood Pressure	_ Yes	_ No	Heart Regurgitation	_ Yes	_ No

**BLOOD DISORDERS**

High Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Blood Transfusions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>AIDS/HIV</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Chronic Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sickle Cell Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

**SYSTEMIC DISORDERS/CANCER**

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

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

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**RESPIRATORY**

Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	COPD	<input type="checkbox"/> Yes	<input type="checkbox"/> No	TB	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No						

**ORTHOPAEDIC CONDITIONS**

Arthritis/Gout	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Artificial Joint	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Joint Replacement	<input type="checkbox"/> Yes	<input type="checkbox"/> No
TMJ	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Plates, Pins or Screws	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hip Replacement	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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

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

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

Yes  No If yes, \_\_\_\_\_

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\_\_\_\_\_  
Signature of Patient, Parent or Guardian

\_\_\_\_\_  
Date

