CHESTERFIELD WOODLAKE
DENTAL & PROSTHODONTICS

Health Information

Patient Name_____

Date of Last Dental Visit_____ Reason for Today's Visit _____

Have you ever had any of the following? Please check and / or circle those that apply:

- ☐ Acid Reflux
- ☐ AIDS/HIV/ARC
- ☐ Alcohol Abuse
- ☐ Allergy - Aspirin
- ☐ Allergy - Codeine
- ☐ Allergy - Latex
- ☐ Allergy - Other
- ☐ Allergy - Red Dye
- ☐ Allergy - Seasonal
- ☐ Allergy - Sulfa
- ☐ Allergy - Amoxicillin
- ☐ Allergy - Dental Anesthetic
- ☐ Allergy - Penicillin
- ☐ Anemia
- ☐ Angioedema
- ☐ Arthritis / Rheumatism
- ☐ Artificial Joints

Type_____

When _____

- ☐ Asthma
- ☐ Blood Clots
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Cancer

Type _____

- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cosmetic Surgery
- ☐ Dementia
- ☐ Dental Phobia
- ☐ Depression
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Disability
- ☐ Dizziness
- ☐ Drug Abuse
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Growths/Tumors
- ☐ Head Injuries
- ☐ Headaches
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Surgery -

Type_____

- ☐ Hepatitis - Type _____
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Meniere's Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ Osteoporosis
- ☐ Other

_____

- ☐ Pacemaker

Year Placed _____

- ☐ Pregnant?

Due Date _____

- ☐ Premedication

Needed - Type _____

- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sinus Problems
- ☐ STD - Type _____
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ TM Disorders
- ☐ Tuberculosis (TB)
- ☐ Ulcers

• Have you ever had any complications following dental treatment? ☐ Yes ☐ No

• Have you ever had unexplained swelling of the lips, face or neck? ☐ Yes ☐ No

If yes, please explain:_____

• Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

If yes, please explain:_____

• Are you now under the care of a physician? ☐ Yes ☐ No

If yes, please explain:_____

• Name of Physician: _____ Phone: _____

• Do you have any health problems that need further clarification? ☐ Yes ☐ No

If yes, please explain:_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____

Signature of Patient, Parent or Guardian

See Reverse Side ➡

CURRENT MEDICATIONS

☐ Not currently taking any medications

Medications you are taking: _____

_____

_____

_____

_____

_____

Signature: _____ Date: _____

STOP HERE.

MEDICATIONS UPDATE

☐ Not currently taking any medications ☐ SAME AS ABOVE

Medications you are taking: _____

_____

_____

_____

_____

_____

Signature: _____ Date: _____

MEDICATIONS UPDATE

☐ Not currently taking any medications ☐ SAME AS ABOVE

Medications you are taking: _____

_____

_____

_____

_____

_____

Signature: _____ Date: _____

POS Reorder # 1905563