



# J SCOTT MAHANEY, DDS

◆ FAMILY & COSMETIC DENTISTRY

## HEALTH INFORMATION

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| <p><b><u>HAVE YOU EVER HAD ANY OF THE FOLLOWING?</u></b></p> <p><input type="radio"/> Y <input type="radio"/> N    AIDS / HIV</p> <p><input type="radio"/> Y <input type="radio"/> N    Alcoholism</p> <p><input type="radio"/> Y <input type="radio"/> N    Anemia</p> <p><input type="radio"/> Y <input type="radio"/> N    Arthritis</p> <p><input type="radio"/> Y <input type="radio"/> N    Artificial Joints</p> <p><input type="radio"/> Y <input type="radio"/> N    Asthma</p> <p><input type="radio"/> Y <input type="radio"/> N    Blood Disorders</p> <p><input type="radio"/> Y <input type="radio"/> N    Cancer</p> <p><input type="radio"/> Y <input type="radio"/> N    Colitis</p> <p><input type="radio"/> Y <input type="radio"/> N    Diabetes</p> <p><input type="radio"/> Y <input type="radio"/> N    Drug Dependency</p> <p><input type="radio"/> Y <input type="radio"/> N    Epilepsy</p> <p><input type="radio"/> Y <input type="radio"/> N    Excessive Bleeding</p> <p><input type="radio"/> Y <input type="radio"/> N    Glaucoma</p> <p><input type="radio"/> Y <input type="radio"/> N    Head Injuries</p> <p><input type="radio"/> Y <input type="radio"/> N    Heart Disease</p> <p><input type="radio"/> Y <input type="radio"/> N    Heart Murmur</p> <p><input type="radio"/> Y <input type="radio"/> N    Hepatitis A, B or C</p> <p><input type="radio"/> Y <input type="radio"/> N    High Blood Pressure</p> <p><input type="radio"/> Y <input type="radio"/> N    Jaundice</p> <p><input type="radio"/> Y <input type="radio"/> N    Kidney Disease</p> <p><input type="radio"/> Y <input type="radio"/> N    Liver Disease</p> <p><input type="radio"/> Y <input type="radio"/> N    Mental Disorder</p> <p><input type="radio"/> Y <input type="radio"/> N    Osteoporosis</p> <p><input type="radio"/> Y <input type="radio"/> N    Pacemaker</p> <p><input type="radio"/> Y <input type="radio"/> N    Radiation Treatment</p> <p><input type="radio"/> Y <input type="radio"/> N    Respiratory Problems</p> <p><input type="radio"/> Y <input type="radio"/> N    Rheumatic Fever</p> <p><input type="radio"/> Y <input type="radio"/> N    Stomach Ulcers</p> <p><input type="radio"/> Y <input type="radio"/> N    Stroke</p> <p><input type="radio"/> Y <input type="radio"/> N    Tuberculosis</p> | <p><b><u>ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING:</u></b></p> <p><input type="radio"/> Y <input type="radio"/> N    Antibiotics</p> <p><input type="radio"/> Y <input type="radio"/> N    Blood Thinners (Coumadin, Plavix)</p> <p><input type="radio"/> Y <input type="radio"/> N    Bisphosphonates (Fosamax, Actonel, Boniva, Reclast or chemotherapy for breast cancer, multiple myeloma)</p> <p><input type="radio"/> Y <input type="radio"/> N    Insulin</p> <p><input type="radio"/> Y <input type="radio"/> N    Pain Medications</p> <p>Please list any other medications you are currently taking and what it is for:</p> <table><tr><td>Medication:</td><td>For:</td></tr><tr><td>_____</td><td>_____</td></tr><tr><td>_____</td><td>_____</td></tr><tr><td>_____</td><td>_____</td></tr><tr><td>_____</td><td>_____</td></tr><tr><td>_____</td><td>_____</td></tr></table> | Medication: | For: | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | <p><b><u>HAVE YOU EVER HAD AN ALLERGIC REACTION TO:</u></b></p> <p><input type="radio"/> Y <input type="radio"/> N    Latex</p> <p><input type="radio"/> Y <input type="radio"/> N    Penicillin</p> <p><input type="radio"/> Y <input type="radio"/> N    Sulfa Drugs</p> <p><input type="radio"/> Y <input type="radio"/> N    Aspirin</p> <p><input type="radio"/> Y <input type="radio"/> N    Ibuprofen</p> <p><input type="radio"/> Y <input type="radio"/> N    Codeine</p> <p><input type="radio"/> Y <input type="radio"/> N    Sedatives</p> <p><input type="radio"/> Y <input type="radio"/> N    Local Anesthetics</p> <p><input type="radio"/> Y <input type="radio"/> N    Epinephrin</p> <p>Other allergic reactions, please list:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> |
| Medication:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | For:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |             |      |       |       |       |       |       |       |       |       |       |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
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| <p><b><u>OTHER INFORMATION</u></b></p> <p><input type="radio"/> Y <input type="radio"/> N    Do you smoke, chew or dip tobacco? If yes, how much per day: _____</p> <p><input type="radio"/> Y <input type="radio"/> N    Are you under the care of a physician(s)?</p> <p>Name of Physician: _____ Phone #: _____</p> <p>_____</p> <p><input type="radio"/> Y <input type="radio"/> N    Have you ever had any serious illness, operations, or hospitalization?</p> <p>If yes, please describe and dates: _____</p> <p>_____</p> <p><input type="radio"/> Y <input type="radio"/> N    Do you have any health problems that aren't mentioned above or that need further clarification?</p> <p>If yes, please describe: _____</p> <p>_____</p> <p>_____</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |             |      |       |       |       |       |       |       |       |       |       |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <p><b><u>DENTAL HISTORY</u></b></p> <p><input type="radio"/> Y <input type="radio"/> N    Are you happy with your smile?</p> <p><input type="radio"/> Y <input type="radio"/> N    Is there anything you would like to change about your smile?</p> <p>If so, please describe: _____</p> <p><input type="radio"/> Y <input type="radio"/> N    Do your gums bleed?</p> <p><input type="radio"/> Y <input type="radio"/> N    Do you suffer from bad breath?</p> <p><input type="radio"/> Y <input type="radio"/> N    Do you grind or clench your teeth?</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <p><b><u>FOR WOMEN ONLY</u></b></p> <p><input type="radio"/> Y <input type="radio"/> N    Are you pregnant or is there any chance you might be pregnant?</p> <p>If yes, due date: _____</p> <p><input type="radio"/> Y <input type="radio"/> N    Are you nursing?</p> <p><input type="radio"/> Y <input type="radio"/> N    Do you understand that taking antibiotics may interfere with the effectiveness of oral contraceptives (birth control)? Alternative methods of birth control should be considered while taking antibiotics.</p>                                                                                                                                                                                                                                                                                                                                                   |             |      |       |       |       |       |       |       |       |       |       |       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |

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 this office of any changes at the next appointment.

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Patient's Date of Birth

\_\_\_\_\_  
Signature of patient, parent or guardian

\_\_\_\_\_  
If Patient is a minor, Relationship to Patient

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Today's Date