Mountain West
FAMILY DENTISTRY

HEALTH HISTORY FORM for Mountain West Family Dentistry

PATIENT NAME _____ **BIRTH DATE** _____/_____/_____

DENTAL INFORMATION

Approximate date of last dental check-up _____

Do you require Pre-medication for cleanings or dental treatment? ☐ **Yes** ☐ **No**

Please list current medications and doses (including over-the-counter and any birth control)

_____ _____

_____ _____

_____ _____

Please list an emergency contact and phone number_____

ALLERGIES:

- ☐ Penicillin
- ☐ Aspirin
- ☐ Codeine
- ☐ Latex
- ☐ Sulfa
- ☐ Other: _____

_____

_____

MEDICAL HISTORY

Women: Pregnant or anticipate becoming pregnant Y / N

Height_____ Weight_____

Physician: Name_____ Phone #_____ Pharmacy_____

Please check if you have any of the following:

Cancer
- ☐ Cancer surgery
- ☐ Chemotherapy
- ☐ Radiation

Cardiovascular
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart attack
- ☐ Stroke/TIA
- ☐ Heart surgery
- ☐ Valve replacement
- ☐ Heart failure
- ☐ Heart murmur
- ☐ Other: _____

Drug Use
- ☐ Tobacco
- ☐ Alcohol abuse
- ☐ Chemical dependency (narcotics)
- ☐ Recreational drugs

Endocrine/Hepatic
- ☐ Diabetes: (circle type: I II)
- ☐ Thyroid disease/problem
- ☐ Liver disease/problem
- ☐ Jaundice
- ☐ Hepatitis: (circle: A B C)

Eyes/Ears
- ☐ Glaucoma
- ☐ Impaired vision
- ☐ Impaired hearing

Gastrointestinal
- ☐ Acid Reflux/GERD
- ☐ Irritable bowel syndrome
- ☐ Stomach ulcers

Hematologic
- ☐ Anemia
- ☐ Sickle cell disease
- ☐ Abnormal/excessive bleeding

Immunologic/Rheumatologic
- ☐ Arthritis
- ☐ Lupus
- ☐ Sjogren's Syndrome

Infections
- ☐ HIV/AIDS
- ☐ STD's/HPV
- ☐ Cold sores/Oral Herpes
- ☐ Tuberculosis
- ☐ Chicken Pox/Shingles

Mental Health
- ☐ Bipolar disorder
- ☐ Depression
- ☐ Anxiety
- ☐ Eating disorder
- ☐ Sleep disorder/Insomnia
- ☐ PTSD/Trauma

Musculoskeletal
- ☐ Artificial joint
- ☐ Fibromyalgia
- ☐ Osteoporosis/Osteopenia
- ☐ Bisphosphonate use

Neurologic
- ☐ Epilepsy/seizures
- ☐ Migraines
- ☐ Parkinson's disease
- ☐ Multiple Sclerosis
- ☐ Alzheimer's/Dementia
- ☐ Autism Spectrum Disorder
- ☐ ADD/ADHD

Renal
- ☐ Dialysis
- ☐ Kidney disorder

Respiratory
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Sleep apnea
- ☐ Difficulty breathing

Skin
- ☐ Hives
- ☐ Other skin lesions/tumors

Please list any other medical concerns not listed and history of surgeries:

_____

_____

_____

_____

_____

I authorize that all the information on this form is true and correct.
I give my permission for the doctor to do all diagnostics and x-rays as required for my treatment.

Signature of Patient/Guardian _____ **Date** _____/_____/_____