HOLISTIC DENTAL CENTER

Discover the missing link to better health

Patient Health History and Medical Information

Check or write in appropriate answer

Patient's Name _____ Date _____

1. Are you in pain or discomfort at this time? _____
2. How would you describe your general health? _____
3. Are you being treated by a physician now or within the last two years? ☐ Yes ☐ No If so, why? _____

   What was the date of your last physical exam? _____

   Physician's name _____ Phone _____

   Address _____
4. Have you had any serious illness, hospitalization or operation? ☐ Yes ☐ No If so, what? _____
5. Are you now or have you taken medication or drugs in the past two years? ☐ Yes ☐ No

   If so, please list: _____
6. Are you taking any supplements, natural remedies or herbs? ☐ Yes ☐ No

   If so, please list: _____
7. Are you allergic to any drugs or medicines? ☐ Yes ☐ No

   If so, please list: _____
8. Do you have or have you ever had any of the following? Check yes or no:

Heart diseases or attack	☐ Yes	☐ No	Kidney or bladder disease	☐ Yes	☐ No	Venereal disease	☐ Yes	☐ No
Chest pain, shortness of breath swollen ankles	☐ Yes	☐ No	Ulcers or heartburn	☐ Yes	☐ No	Genital herpes	☐ Yes	☐ No
Heart murmur	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	AIDS/HIV positive	☐ Yes	☐ No
Allergies, hives	☐ Yes	☐ No	Asthma, TB, emphysema	☐ Yes	☐ No	Physical disability	☐ Yes	☐ No
Mitral valve prolapse	☐ Yes	☐ No	Persistent cough	☐ Yes	☐ No	Anemia	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Drug addiction	☐ Yes	☐ No
Heart surgery	☐ Yes	☐ No	Thyroid problems	☐ Yes	☐ No	Hepatitis A, B, or C	☐ Yes	☐ No
Rheumatic fever	☐ Yes	☐ No	Eye disease or problems	☐ Yes	☐ No	Psychiatric treatment	☐ Yes	☐ No
Arthritis or rheumatism	☐ Yes	☐ No	High blood pressure	☐ Yes	☐ No	Depression	☐ Yes	☐ No
Joint replacement	☐ Yes	☐ No	Liver disease	☐ Yes	☐ No	Chronic diarrhea or constipation	☐ Yes	☐ No
Cancer or tumor	☐ Yes	☐ No	Sinus problems	☐ Yes	☐ No	Premedication for dental treatment	☐ Yes	☐ No
Fainting or dizziness	☐ Yes	☐ No	Radiation/chemotherapy	☐ Yes	☐ No			
			Excessive bleeding	☐ Yes	☐ No			

9. Do you have any disease, condition or problem not listed above? ☐ Yes ☐ No

   Explain: _____
10. Are you on a special diet? ☐ Yes ☐ No
11. Have you ever been on the phen-fen diet? ☐ Yes ☐ No
12. Do you smoke or use tobacco in any form? ☐ Yes ☐ No
13. Do you use recreational drugs? ☐ Yes ☐ No
14. Are you pregnant? ☐ Yes ☐ No Are you using birth control? ☐ Yes ☐ No
15. Have you been tested for or told that you have excessive amounts of heavy metals, including mercury, in your body? ☐ Yes ☐ No
16. Do you feel that you might have symptoms of mercury or metal toxicity? ☐ Yes ☐ No

To the best of my knowledge, all of the preceding answers are true and correct. If I have any change in my health or medicines, I will inform the dentist or hygienist at my next appointment.

Signed _____ Date _____

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Initials	Reviewed on	Initials	Reviewed on	Initials	Reviewed on