Pennington Dental Center

Medical Health History

Patient Name: _____ DOB: _____ Date: _____

Date of last health care exam by a medical doctor: _____ What was exam for: _____

Have you been hospitalized in the last 5 years? (Please Circle) No Yes For What? _____

Are you currently receiving medical care? No Yes If yes, nature of care: _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____ 2. _____

For the following questions circle yes or no if you have ever been diagnosed, or treated in the past, or are now being treated for, or are aware of any of the following. **Your answers are for our records only and will be confidential.** *Please note that during your initial visit you will be asked some questions about your response. Our team may as additional questions concerning your health.*

Anemia or Blood Disorder	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease	No	Yes	Joint Replacement Year placed	No	Yes
Asthma	No	Yes	Kidney Disease or Problems	No	Yes
Inhaler, Advair, Breathing Treatments	No	Yes	Liver Disease (including Jaundice) or Problems	No	Yes
Cancer or Tumor Year	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes (HbA1C #)	No	Yes	Numbness in feet or toes	No	Yes
Emphysema or other Respiratory/Lung Illness	No	Yes	Previous Biopsies Year	No	Yes
Epilepsy	No	Yes	Radiation or chemotherapy Treatment Year	No	Yes
Glaucoma/Eye Problems	No	Yes	Slow-Healing Mouth Sores	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes	H.I.V. infection/AIDS or ARC	No	Yes
Congenital Heart Disease	No	Yes	Sexually Transmitted Condition	No	Yes
Heart Disease, Heart Attack, Heart Surgery	No	Yes	Heart murmur/Irregular Heart Beat	No	Yes
Heart Stent Year Placed	No	Yes	Rheumatic Fever	No	Yes
Coumadin/Blood Thinners	No	Yes	Recurrent Illness	No	Yes
Depression/Panic Attacks/Mood Swings	No	Yes	Migraine/Severe Headaches	No	Yes
Sleep Difficulties/Sleep Apnea	No	Yes	Stomach Ulcers/Problems/Reflux	No	Yes
High Blood Pressure	No	Yes	High Cholesterol	No	Yes
Mitral-Valve Prolapse	No	Yes	Previous Alcohol or Drug Abuse/Addiction	No	Yes
Fainting or Dizzy Spells/Angina	No	Yes	Psychological issues/Post Traumatic Stress	No	Yes
Blood Transfusion Year	No	Yes	Abnormal Bleeding from a cut	No	Yes
Leukemia	No	Yes	Thyroid Problem	No	Yes
Cardiac Pacemaker	No	Yes	Joint Replacement, implant, pins, plates or screws	No	Yes
Angina, Chest pains	No	Yes	Stroke	No	Yes
Tuberculosis	No	Yes	Respiratory Problems	No	Yes
Hay Fever, Allergies	No	Yes			

Do you have or have you had any other diseases, conditions or medical problems NOT listed on this form?

Have you ever received a diagnosis of "high blood pressure"? No Yes
What is your normal blood pressure? _____/_____ **Today:** _____/_____
Height: Weight:

Are you taking any of these medications?

Pre-Medication before dental treatment	No	Yes	Tagamet (cimetidine) or Prilosec (omeprazole)	No	Yes
Antacids (Pepsid AC, etc)	No	Yes	CadiZem (dilitiaZem) or Calan, Isoptin (Verapamil)	No	Yes
Barbiturates (any)	No	Yes	Diflucan (fluconazole) or Sporonox (itraconazole)	No	Yes
St. John's Wort or Kava-Kava	No	Yes	Biaxin (clarithromycin), Erythromycin	No	Yes
Lunesta, Ambien	No	Yes	Tetracycline,Doxycycline	No	Yes
Dilantin or Tegretol	No	Yes	Serzone (nefazodone)	No	Yes
Do you consume grapefruit juice, grapefruit extract	No	Yes	Have you ever taken any prescription drugs such as fen-phen for weight loss	No	Yes
Have you been treated with Bisphosphonate drugs (Fosamax, Aredia, Zometa, Acotonel, Boniva) If so, when did the treatment begin: When did treatment end:				No	Yes

List any medications (prescription, over the counter, herbal) taken on a daily basis:

Women:

Are you Pregnant?	No Yes	Your Due date:
Are you a nursing mother?	No Yes	
Are you using any birth control contraceptives? (pills, injections/shots, IUD (Mirena)	No Yes	

Are you allergic or have you had a reaction to:

Local anesthetics	No	Yes	Codeine, Valium, or other sedatives	No	Yes
Penicillin or other antibiotics	No	Yes	Latex or Metals	No	Yes
Aspirin, Ibuprofen or Tylenol	No	Yes	Sulfa Drugs, Iodine	No	Yes
Other (please specify)					

Do you use tobacco No Yes If yes, type: smoke chew dip How much per day How long

I understand that scheduled times are appointed to provide quality care for our patients. Therefore, it is important for me to maintain my scheduled appointments. And, that this office reserves the right to charge for appointments cancelled or broken without 24 hour advanced notice. I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist any insurance benefits otherwise payable to me. Returned checks and balances over 30 day will be subject to finance charges and possible late fees. I understand balances older than 60 days may be subject to reasonable additional collection fees. Returned checks and balances over 90 days will be turned over to a collection agency unless other arrangements are made with our office. Fees will be added by the out side collection agency used by Brent Pennington DMD,LLC to assist in collecting past due accounts.

_____ _____ _____

Patient (Print Name) Patient Signature Date

Recall Review:

1. Patient's signature: _____ Date: _____
2. Patient's signature: _____ Date: _____
3. Patient's signature: _____ Date: _____
4. Patient's signature: _____ Date: _____