Kona Coast Dental Care

CONFIDENTIAL HEALTH HISTORY FORM

Patient Name _____ Birth Date:_____

Dental Questions

Pain or discomfort in your mouth or jaw?	Yes □	No □
Do you grind or clench your teeth?	Yes □	No □
Frequent headaches?	Yes □	No □
Bleeding gums?	Yes □	No □
Periodontal treatment?	Yes □	No □
Orthodontic treatment?	Yes □	No □
Do you have dental implants?	Yes □	No □

Physicians Name _____Number_____

Medical Questions

Have you ever been hospitalized or had a major operation?	Yes □	No □
Have you ever had a joint replacement? Year? Type?	Yes □	No □
Have you ever had a serious head or neck injury?	Yes □	No □
Are you taking any medications? List of medications:	Yes □	No □
Do you take or have you taken Fosamax, Boniva, Actonel, or any other medications for Osteoporosis? When?	Yes □	No □
Do you Use Tobacco? Smoke or Chew?	Yes □	No □
Do you use controlled substances? Type?	Yes □	No □
Have you had Cancer? Year? Type?	Yes □	No □
Have you received Chemotherapy or Radiation therapy? When?	Yes □	No □

□Pregnant □Nursing □Taking Oral Contraceptives

Please fill out the front and back side of this form

Are you allergic to any of the following?

□Aspirin □Penicillin □Codeine □Metals □Latex □Sulfa Drugs □Dental Anesthetic

Any Other Allergic Reactions Please List:

Have you ever been diagnosed with the following?

AIDS.....Yes □ No □	Hepatitis A.....Yes □ No □
HIV.....Yes □ No □	Hepatitis B or C.....Yes □ No □
Alzheimer's Disease.....Yes □ No □	Herpes.....Yes □ No □
Anemia.....Yes □ No □	High Blood Pressure.....Yes □ No □
Angina.....Yes □ No □	High Cholesterol.....Yes □ No □
Arthritis/Gout.....Yes □ No □	Hives or Rash.....Yes □ No □
Artificial Heart Valve.....Yes □ No □	Hypoglycemia.....Yes □ No □
Artificial Joint.....Yes □ No □	Irregular Heartbeat.....Yes □ No □
Asthma.....Yes □ No □	Kidney Problems.....Yes □ No □
Blood Disease.....Yes □ No □	Leukemia.....Yes □ No □
Bleeding Disorder.....Yes □ No □	Low Blood Pressure.....Yes □ No □
Cancer.....Yes □ No □	Lung Disease.....Yes □ No □
Congenital Heart Disorder.....Yes □ No □	Psychiatric Disease.....Yes □ No □
Diabetes.....Yes □ No □	Recent Weight Loss.....Yes □ No □
Drug Addiction.....Yes □ No □	Rheumatic Fever.....Yes □ No □
Emphysema.....Yes □ No □	Sickle Cell Disease.....Yes □ No □
Fainting spells/Dizziness.....Yes □ No □	Sinus Trouble.....Yes □ No □
Heart Attack.....Yes □ No □	Sleep Apnea..... Yes □ No □
Heart Murmur.....Yes □ No □	Stroke.....Yes □ No □
Heart Pacemaker.....Yes □ No □	Thyroid Disorder.....Yes □ No □
Mitral Valve Prolapse.....Yes □ No □	Tonsillitis.....Yes □ No □
Osteoporosis.....Yes □ No □	Tuberculosis.....Yes □ No □
Heart trouble/Disease.....Yes □ No □	Ulcers.....Yes □ No □
	Venereal Disease.....Yes □ No □

To The Best of my knowledge, the questions have been accurately answered. I understand that providing incorrect information can be dangerous for my (or patient's) health. It is my responsibility to inform Kona Coast Dental Care of any changes in medical status. I hereby Authorize Kona Coast Dental Care to perform dental treatment necessary for my health.

Signature of Patient, Parent or Legal Guardian:

X Date:

If you are a Legal Guardian, specify relationship:

Please fill out the front and back side of this form