Park Place Health & Dental Clinic- Health History

Name (first middle last)	Date of Last Treatment	Date of Birth
Emergency Contact Name:	Relationship to patient	Emergency Contact Phone #

Are you now under the care of a physician? ☐**Yes** ☐ **No**

Are you taking **any** drug(s) or medicine(s), including over-the-counter? ☐**Yes** ☐ **No**
If yes, please list the medicine(s) : ____

____

Are you **allergic** or have you had **a reaction** to any of the following? ☐**NO** ☐**Yes (Please check those that apply)**:

☐ **Local anesthetics**
☐ **Sedatives**
☐ **Barbiturates**
☐ **Penicillin or other Antibiotics**

☐ **Sulfa or Sulfa Drugs**
☐ **Aspirin**
☐ **Codeine**
☐ **Iodine**

Place Medical
Alert Sticker Here

Other please list____

Are you pregnant? ☐**Yes** ☐ **No**

Do you **have** or **have you had any** of the following diseases or problems? **Please mark an "X" by your choice**.

	Yes	No	Not Sure		Yes	No	Not Sure
Epilepsy or seizures	☐	☐	☐	*Heart Surgery*	☐	☐	☐
Fainting or dizziness	☐	☐	☐	*Heart Problems or Angina*	☐	☐	☐
Nervousness	☐	☐	☐	**Hypertension (High Blood Pressure)**	☐	☐	☐
Stroke	☐	☐	☐	*Rheumatic Fever*	☐	☐	☐
Glaucoma	☐	☐	☐	Heart Murmur	☐	☐	☐
Cold sores (Herpes)	☐	☐	☐	*Mitral Valve Prolapse*	☐	☐	☐
Emphysema	☐	☐	☐	**Pacemaker**	☐	☐	☐
Tuberculosis	☐	☐	☐	Blood transfusion	☐	☐	☐
Asthma	☐	☐	☐	**Liver Disease**	☐	☐	☐
Hay Fever	☐	☐	☐	**Hepatitis – Type ___**	☐	☐	☐
Sinus Problems	☐	☐	☐	Ulcers	☐	☐	☐
Anemia	☐	☐	☐	Kidney Problems	☐	☐	☐
Sickle Cell Disease	☐	☐	☐	**Venereal disease**	☐	☐	☐
Diabetes	☐	☐	☐	*Joint Replacement*	☐	☐	☐
Bruise or Bleed easily	☐	☐	☐	*Dialysis*	☐	☐	☐
Transplants	☐	☐	☐	Do you or have you used tobacco	☐	☐	☐
HIV Positive/AIDS	☐	☐	☐	Products? How long?_____ Date stopped _______			

(*Italics=Medical Alert and Pre-medicate*) (**Bold** = Medical Alert)

Do you have any disease, condition or health problem not listed above?
☐**Yes** ☐ **No**
If yes, please explain: ____

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I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the Dental Staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

Signature	**Date**	**Office Use Only**
Renewal Signature- Sign After Yearly Review	***Renewal Date***	***Office Use Only***