New Haven Dental Group *Health Information*

Name: _____ Sex: ☐ Male ☐ Female
Last First MI

Date of Birth: _____ Date of Last Dental Visit: _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No

  If yes, please explain: _____

- Has your physician advised you to be premedicated with antibiotics before dental work? ☐ Yes ☐ No
- Are you now under the care of a physician? ☐ Yes ☐ No

  If so, what condition is being treated?: _____

- Have you had any serious illness, operation, or been hospitalized in the past five years? ☐ Yes ☐ No

  If yes, please explain: _____

- List all prescription and non-prescription medications you are taking: (Include birth control pills)

_____

_____

_____

- Name of Physician: _____ Phone: _____

_____
Street City State Zip Code

- My last physical examination was on _____

Have your ever had any of the following? Please check those that apply:

☐ Abnormal Bleeding
☐ AIDS
Allergies to:
- ☐ Aspirin
- ☐ Barbiturates
- ☐ Codeine
- ☐ Local Anesthetics
- ☐ Penicillin
- ☐ Sedatives
- ☐ Sleeping Pills
- ☐ Sulfa Drugs

☐ Allergies (Other)
_____
_____
_____

☐ Anemia
☐ Angina
☐ Arteriosclerosis
☐ Arthritis
☐ Artificial Heart Valve
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Blood Transfusions
☐ Bronchitis
☐ Cancer
☐ Coronary Insufficiency
☐ Coronary Occlusion
☐ Damaged Heart Valve
☐ Diabetes
☐ Dizziness
☐ Emphysema
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting Spells
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injury
☐ Heart Attack
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ HIV +
☐ Inborn Heart Defects
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Low Blood Pressure
☐ Mental Disorders
☐ Mitral Valve Prolapse
☐ Nervous Disorders
☐ Pacemaker
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Seizures
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Swollen Neck Glands
☐ Thyroid Problems
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
OTHER:
☐ _____
☐ _____

- Have you ever had a skin reaction to jewelry or other metals? ☐ Yes ☐ No
- Do any health problems need further clarification? ☐ Yes ☐ No

  If yes, please explain: _____

_____

If you are pregnant or recently gave birth what is/was your due date? _____ Are you nursing? ☐ Yes ☐ No

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian