Patient Health History
Learman Dental

Today's Date _____

Patient Name: _____ Date of Birth: _____ Age: _____

Emergency Contact: _____ Emerg Contact Phone: _____

What is your general health? GOOD FAIR POOR

Are you currently under the care of a physician? YES NO Last physical exam: _____

If yes, please explain: _____

Physician Name: _____ Physician Phone: _____

Do you normally premedicate (take antibiotics) prior to having dental treatment or dental cleanings?_____

If yes, please explain? _____

GENERAL CONDITIONS:

Y N Significant weight change
Y N Present/past tobacco use (smoke or chew)
How much? _____
Y N Present/past alcohol use
How much? _____
Y N Present/past recreational drug use

SPECIFIC CONDITIONS:

Skin

Y N Eruptions/rash/hives
Y N Frequent cold sores/fever blisters

Eyes:

Y N Visual changes
Y N Glaucoma
Y N Contact lenses
Y N Other/surgery _____

Ears:

Y N Hearing loss
Y N Ringing in ears
Y N Pain/discomfort around ears

Respiratory:

Y N Tuberculosis
Y N Emphysema
Y N Asthma/hay fever
Y N Hoarseness/sore throat
Y N Other _____

Male:

Y N Prostate disorders

Female:

Y N Pregnant; # months _____
Due date _____
Y N Breast-feeding
Y N Birth control pills

Endocrine

Y N Diabetes
Y N Thyroid condition
Y N Hormone imbalance

Nervous system

Y N Stroke
Y N Epilepsy/seizures
Y N Head or neck injuries
Y N Numbness/tingling
Y N Dizziness/fainting

Bones, muscles

Y N Arthritis/Rheumatism
Y N Artificial joints/limbs
Y N Osteoporosis
Y N Fibromyalgia

Digestive

Y N Hepatitis (Type _____)
Y N Ulcers
Y N Colitis
Y N Gastric Reflux (GERD)
Y N Other _____

OVER

Heart, blood vessels

Y N Heart problems/trouble
Y N Chest pain/discomfort
Y N Heart murmur
Y N Mitral valve prolapse
Y N Congenital heart defect
Y N Pacemaker
Y N Artificial heart valve
Y N High Blood Pressure
Y N Low Blood Pressure
Y N Heart surgery
Y N High cholesterol
Y N Other _____

Urinary:

Y N Kidney disease
Y N Venereal disease
Y N Increased frequency of urination

Blood:

Y N Anemia or other blood disorders
Y N Bruise easily

Have You Ever Taken Any of These Medications:

Y N Bisphosphonates
Y N Actonel
Y N Boniva
Y N Fosamax
Y N Reclast
Y N Zometa

OTHER

Y N Cancer
Y N Radiation/Chemotherapy
Y N Lumps/growths
Y N HIV/AIDS
Y N Emotional problems
Y N Easily upset or irritated
Y N Unhappy/ depressed
Y N Psychiatric treatment
Y N Human Papilloma (HPV)

ALLERGIES, REACTIONS:

Y N Dental anesthesia
Y N Penicillin/other _____
Y N Sulfa drugs
Y N Aspirin/Codeine
Y N Barbiturates/sedatives
Y N Latex
Y N Metals/jewelry
Y N Other_____

SLEEP MEDICINE:

Y N Snore or Gasp?
Y N Tired during the day?
Y N Ever had sleep test?
When _____ Where_____
Y N Diagnosed Sleep Apnea
Y N Wear CPAP?
Y N Clench or grind teeth?
Y N Headaches or sore jaw?

MEDICATIONS:

Please list names of current medication(s)

_____
_____
_____
_____

Are there any other diseases, conditions or problems not listed that you think we should know about?

_____

The above information is true to the best of my knowledge. Should further information be needed, you have my permission to ask the respective healthcare provider, who may release such information to you. I will inform you of any changes in my health or medications.

Signature: _____ Reviewed by: _____ Date: _____