REIGN DENTAL

Health History

Patient Name: ______________________________ Date_______________

Are you having dental pain?____

Are you in good health?____

Are you taking any medication: ______If yes, please list: ___________________

____

Have you been hospitalized in the last 10 years?____________________________

When was your last physical?____________Physicians Name:_________________

Do you smoke/chew tobacco?____________Physicians Phone #_______________

Do you have or are you being treated for:

Y N Allergies to medication ______________________________
Y N Reactions to Local Anesthetics ______________________________
Y N Allergies/Reactions to Antibiotics ______________________________
Y N Asthma, Hay fever or other allergies ______________________________
Y N Cancer: Radiation or Chemotherapy ______________________________
Y N Liver Disease ______________________________
Y N Kidney Disease ______________________________
Y N Heart Disease ______________________________
Y N Stroke ______________________________
Y N High Blood Pressure ______________________________
Y N Heart Murmur ______________________________
Y N Excessive Bleeding ______________________________
Y N Diabetes / Hypoglycemia ______________________________
Y N Epilepsy or Seizures ______________________________
Y N Rheumatic Fever ______________________________
Y N Hepatitis A – B – C ______________________________
Y N Tuberculosis / Lung Disease ______________________________
Y N Are you Pregnant ______________________________
Y N Have you donated blood in the last 10 years
Y N Have you been tested for HIV__________Date:_________________________
Y N Do you have any reason to think you are HIV positive?_________________
Medication:_____________________________
Y N Do you have any prosthesis? ______________________________
(Artificial Joints, Heart valves – pacemaker or pins) Y N
Depression Therapy ______________________________ Y N
Alcohol or Drug related Therapy ______________________________ Y N
Pre-Medication Necessary for a Dental Appointment___Type:______________

I certify that the above information is current and correct and that I will notify this office of any changes.

Patients Signature:________________________________ Date:____________

Dentists Signature:________________________________ Date:____________