Time 12:27 PM | Clinton Dental Care | Date 6/28/2023

Patient Health Form 2023

Patient Name: | Birth Date: | Date Created:

Physician Health/Contacts

Are you currently under a general physician's care? ◯ Yes ◯ No If yes

Are you currently seeing a cardiologist or other specialist? ◯ Yes ◯ No If yes

Sleep History

Do you notice that you have trouble sleeping through the night? ◯ Yes ◯ No

Have you been told you snore? ◯ Yes ◯ No

Do you currently wear a CPAP device? ◯ Yes ◯ No

Medications/Allergies

Taking any medications? PLEASE LIST ALL BELOW... ◯ Yes ◯ No If yes

Are you allergic to any of the following?

Acrylic	◯ Yes ◯ No	Anesthetics(Local)	◯ Yes ◯ No	Codeine	◯ Yes ◯ No
Latex	◯ Yes ◯ No	Metal	◯ Yes ◯ No	Penicillin	◯ Yes ◯ No
Sulfa Drugs	◯ Yes ◯ No	Other	◯ Yes ◯ No		

Have you had, or do you currently have any of the following?

Acid Reflux	◯ Yes ◯ No	Anemia	◯ Yes ◯ No	AIDS/HIV	◯ Yes ◯ No	Anaphylaxis	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Asthma/COPD/Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No
Cancer/Radiation Treatments	◯ Yes ◯ No	Cold Sores/Mouth Ulcers	◯ Yes ◯ No	Cortisone Treatments	◯ Yes ◯ No	Chlosterol Concerns	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Epilepsy/Seizures	◯ Yes ◯ No	Heart Attack/Stroke	◯ Yes ◯ No
Heart Valve Surgery/Infective Endocardit	◯ Yes ◯ No	Heart Murmur/AFib/Pacemaker	◯ Yes ◯ No	Hepatitis (A, B, or C)	◯ Yes ◯ No	Jaw Pain/ TMD	◯ Yes ◯ No
Kidney or Liver Disease	◯ Yes ◯ No	Joint Replacement	◯ Yes ◯ No	Lupus/Auto-Immune Disease	◯ Yes ◯ No	Osteoporosis/Osteopenia	◯ Yes ◯ No
Sinus/Tonsil Surgery	◯ Yes ◯ No	Shingles	◯ Yes ◯ No	Hyper-Thyroid	◯ Yes ◯ No	Hypo-Thyroid	◯ Yes ◯ No
Tuberculosis	◯ Yes ◯ No	Recent Weight Gain/Loss	◯ Yes ◯ No	Well water	◯ Yes ◯ No		

Do you have any serious illess that is NOT listed above? ◯ Yes ◯ No If yes

Emergency Contact Information

Although dental personnel primarily treat the in and around areas of your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform and update the dental office of any changes to my medical history/status.

Signature of Patient, Parent or Guardian:

X Date:_____