NEW ORLEANS HCH DENTAL CLINIC

Dental Health History

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of last visit\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AIDS/HIV+ \_\_Yes \_\_No

Alcoholism \_\_Yes\_\_No

Anemia \_\_Yes \_\_No

Arthritis, Rheumatism \_\_Yes \_\_No

Artificial Heart Valves \_\_Yes \_\_No

Artificial Joints (Pins or Rods) \_\_Yes\_\_No

Asthma \_\_Yes\_\_No

Back Problems \_\_Yes\_\_No

Bleeding abnormally, with \_\_Yes\_\_No

 extractions or surgery

Blood Disease \_\_Yes\_\_No

Cancer \_\_Yes\_\_No

Chemical Dependency \_\_Yes\_\_No

Chemotherapy \_\_Yes\_\_No

Circulatory Problems \_\_Yes\_\_No

Congenital Heart Lesions \_\_Yes\_\_No

Cortisone Treatments \_\_Yes\_\_No

Cough - persistent or bloody \_\_Yes\_\_No

Diabetes \_\_Yes\_\_No

Emphysema \_\_Yes\_\_No

Epilepsy or Seizures \_\_Yes\_\_No

Fainting or dizziness \_\_Yes\_\_No

Glaucoma \_\_Yes\_\_No

Headaches \_\_Yes\_\_No

Heart Murmur \_\_Yes\_\_No

Heart Problems \_\_Yes\_\_No

Hepatitis Type\_\_\_\_\_\_\_ \_\_Yes\_\_No

Herpes or other STD \_\_Yes\_\_No

High Blood Pressure \_\_Yes\_\_No

High Cholesterol \_\_Yes\_\_No

Jaundice \_\_Yes\_\_No

Jaw Pain \_\_Yes\_\_No

Kidney Disease \_\_Yes\_\_No

Liver Disease \_\_Yes\_\_No

Low Blood Pressure \_\_Yes\_\_No

Mitral Valve Prolapse \_\_Yes\_\_No

Nervous Problems \_\_Yes\_\_No

Osteoporosis/Bone Disease \_\_Yes\_\_No

Pacemaker \_\_Yes\_\_No

Psychiatric Care

 Anxiety \_\_Yes\_\_No

 Bipolar \_\_Yes\_\_No

 Depression \_\_Yes\_\_No

 \_\_\_\_\_\_\_\_\_\_\_\_ \_\_Yes\_\_No

Radiation Treatment \_\_Yes\_\_No

Respiratory Disease \_\_Yes\_\_No

Rheumatic Fever \_\_Yes\_\_No

Scarlet Fever \_\_Yes\_\_No

Sinus (allergy) Problems \_\_Yes\_\_No

Shortness of Breath \_\_Yes\_\_No

Skin Rash \_\_Yes\_\_No

Special Diet \_\_Yes\_\_No

Stroke \_\_Yes\_\_No

Swollen Feet or Ankles \_\_Yes\_\_No

Swollen Neck Glands \_\_Yes\_\_No

Thyroid Problems \_\_Yes\_\_No

Tuberculosis \_\_Yes\_\_No

Tumor or growth on head \_\_Yes\_\_No

 or neck

Ulcer \_\_Yes\_\_No

Venereal Disease \_\_Yes\_\_No

Weight Loss, unexplained \_\_Yes\_\_No

Problem Not Listed\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_Yes\_\_No

Are you Pregnant? \_\_Yes\_\_No

Taking birth control pills? \_\_Yes\_\_No

Are you taking heart medication? \_\_Yes\_\_No

Are you on Blood Thinner? \_\_Yes\_\_No

ALLERGIES

Aspirin \_\_Yes\_\_No

Codeine \_\_Yes\_\_No

Iodine \_\_Yes\_\_No

Latex \_\_Yes\_\_No

Local Anesthetic \_\_Yes\_\_No

Penicillin \_\_Yes\_\_No

Sulfa \_\_Yes\_\_No

NSAIDS (Ibuprofen, Naproxen) \_\_Yes\_\_No

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_Yes\_\_No

SMOKER \_\_Yes\_\_No

LIST CURRENT MEDICATIONS (incomplete list will delay treatment)

Medication Dosage

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

Use back of form if necessary

Patient/Parent Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dentist Initial:\_\_\_\_\_\_\_\_

BP\_\_\_\_\_\_\_\_\_Pulse\_\_\_\_\_\_\_\_Perio\_\_\_\_\_\_\_\_\_\_\_

10/2024