Patient Health Disclosure Form

First Name
-

Last Name
-

Date of Birth
-

Preferred Name
-

Name of Physician
-

Physician's speciality
-

Which was the most recent physical examination done?
-

Purpose of physical examination
-

How would you rate the condition of your general health?
-

Do you presently have or have you ever had any of the following?

1. Hospitalization for illness or injury
-

2. An allergic or bad reaction to any of the following:
-

- ☐ Aspirin, ibuprofen, acetaminophen, codeine
- ☐ Penicillin
- ☐ Erythromycin
- ☐ Tetracycline
- ☐ Sulfa
- ☐ Local anesthetic
- ☐ Fluoride
- ☐ Chlorhexidine(CHX)
- ☐ Metals (nickel, gold, silver, etc)
- ☐ Latex
- ☐ Nuts
- ☐ Fruit
- ☐ Other

If metals, please specify:
-

If nuts, please specify:
-

If fruit, please specify:
-

If other, please specify:
-

3. Heart problems, or cardiac stent within the last six months
-

4. History of infective endocarditis
-

5. Artificial heart valve, repaired heart defect (PFO)
-

6. Pacemaker or implantable defibrillator
-

7. Orthopedic implant (joint replacement)
-

8. Rheumatic or scarlet fever
-

9. High or low blood pressure
-

10. Stroke (taking blood thinners)
-

11. Anemia or other blood disorder
-

12. Prolonged bleeding due to a slight cut (INR > 3.5)
-

13. Pneumonia, emphysema, shortness of breath, sarcoidosis
-

14. Chronic ear infections, tuberculosis, measles, chicken pox
-

15. Asthma
-

16. Breathing or sleep problems (i.e. sleep apnea, snoring, sinus)
-

17. Kidney disease
-

18. Liver disease
-

19. Jaundice
-

20. Thyroid, parathyroid disease, or calcium deficiency
-

21. Hormone deficiency
-

22. High cholesterol or taking statin drugs
-

23. Diabetes
-

HbA1c
-

24. Stomach or duodenal ulcer
-

25. Digestive or eating disorders (i.e. celiac disease, gastric reflux, bulimia, anorexia)
-

26. Osteoporosis/osteopenia (i.e. taking bisphosphonates)
-

27. Arthritis
-

28. Autoimmune disease (i.e. rheumatoid arthritis, lupus, scleroderma)
-

29. Glaucoma
-

30. Contact lenses
-

31. Head or neck injuries
-

32. Epilepsy, convulsions (seizures)
-

33. Neurologic disorders (ADD/ADHD, prion disease)
-

34. Viral infections and cold sores
-

35. Any lumps or swelling in the mouth
-

36. Hives, skin rash, hay fever
-

37. STI / STD / HPV
-

38. Hepatitis
-

Please specify the type of hepatitis:
-

39. HIV / AIDS
-

40. Tumor, abnormal growth
-

41. Radiation therapy
-

42. Chemotherapy, immunosuppressive medication
-

43. Emotional difficulties
-

44. Psychiatric treatment
-

45. Antidepressant medication
-

46. Alcohol / recreational drug use
-

Are you:

47. Presently being treated for any other illness
-

48. Aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea)
-

49. Taking medication for weight management
-

50. Taking dietary supplements
-

51. Often exhausted or fatigued
-

52. Experiencing frequent headaches
-

53. A smoker, smoked previously or use smokeless tobacco
-

54. Considered a touchy / sensitive person
-

55. Often unhappy or depressed
-

56. Taking birth control pills
-

57. Currently pregnant
-

58. Diagnosed with a prostate disorders
-

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)
-

List all medications, supplements, and or vitamins taken within the last two years. (Name of the Drug and purpose of taking)
-

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING

Patient's Signature (ESign)

Date :