BEECHCROFT DENTAL

Patient Name_____

Health History

Are you currently under a physicians care? Yes No If yes, please explain _____

Have you recently been hospitalized? Yes No If yes, please explain_____

Are you taking any medications? Yes No If yes, please list_____

Do you take Aspirin, Coumadin, or Plavix? Yes No

Have you ever taken Fosamax, Boniva, Actenol or any other medications containing bisphosphonates? Yes No

Do you use tobacco? Yes No

Women Only

Are you:
Pregnant Yes No
Nursing Yes No
Taking Oral Contraceptives Yes No

Are you allergic to any of the following?

Aspirin Penicillin Local Anesthetics Codeine
Acrylic Metal Sulfa Drugs
Other If yes, please explain_____

Medical History

Do you or have you had any of the following?

Yes	No	Tuberculosis Active? Y N	Yes	No	Heart Attack	Yes	No	Mitral Valve Prolapse
Yes	No	Emphysema	Yes	No	Thyroid Problems	Yes	No	Kidney Problems
Yes	No	Cardiovascular Disease	Yes	No	Heart Murmur	Yes	No	Pacemaker
Yes	No	Sinus Trouble	Yes	No	Stroke	Yes	No	Osteoporosis
Yes	No	Angina	Yes	No	Asthma	Yes	No	Rheumatic Fever
Yes	No	Artificial Heart Valve	Yes	No	Hepatitis	Yes	No	Headaches/Migraines
Yes	No	Congestive Heart Failure	Yes	No	Low Blood Pressure	Yes	No	Anemia
Yes	No	Cancer	Yes	No	Epilepsy	Yes	No	Glaucoma
Yes	No	Arthritis	Yes	No	High Blood Pressure	Yes	No	Hemophilia
Yes	No	Diabetes-Type I / Type II	Yes	No	Seizures	Yes	No	STD's
Yes	No	Artificial Joint	Yes	No	Congenital Heart Disorder	Yes	No	HIV/AIDS
Yes	No	Ulcers	Yes	No	Mental Health Disorders	Yes	No	Shingles

Dental History

Yes No Are you happy with your smile?
Yes No Are you experiencing pain or discomfort?
Yes No Do your gums bleed when you brush or floss?
Yes No Do you have any clicking, popping, or discomfort in the jaw?
Yes No Do you grind your teeth?
Yes No Do you have sores or ulcers in your mouth?
Yes No Do you have earaches or neck pain?
Yes No Have you had orthodontic (braces) treatment?
Yes No Have you had any problems with previous dental treatments?
Yes No Have you had periodontal (gum) treatments?
Yes No Do you wear dentures or partials?
Yes No Does food or floss catch between your teeth?
Yes No Are your teeth sensitive to hot, cold, sweets, or pressure?
Yes No Has a previous physician or dentist recommended that you take antibiotics prior to your dental treatment?
Yes No Do you or has a doctor prescribed you to use a CPAP machine?

Any additional information you would like us to know:

I understand that the information I have given today is correct to the best of my knowledge. I also understand this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status.

_____
Signature of Patient, Parent or Guardian