Petaluma Dental Group

Patient Health History

Please take time to fill out this form completely. The more we learn about you the better care we can provide.
We look forward to working with you to maintain a healthy, happy relationship.

Date _____ First Name _____ MI _____ Last Name _____

	Yes	No
Within the past year, have there been any changes in your general health?	☐	☐
Have you ever been told you need pre-medication prior to a dental appointment?	☐	☐
Antibiotics	☐	☐
Sedation	☐	☐

Have you had any recent traumas? (if yes, describe below)

Description:_____

What is the approximate date of your last medical physical exam? _____

Please list your physician's information below: **Medical Record and/ or Kaiser Number:** _____

Physicians Name	Location	Contact Information
Primary		
Specialist		
Specialist		

Are you, or have you taken any of the following medications or supplements in the past three months?

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Aloe Vera	☐	☐	Garlic	☐	☐	Phosphate	☐	☐	Vitamin B6
☐	☐	Antibiotics	☐	☐	Ginger	☐	☐	Phosphorus	☐	☐	Vitamin B12
☐	☐	Aspirin	☐	☐	Gingko Biloba	☐	☐	Potassium	☐	☐	Vitamin C
☐	☐	Bisphosphonate	☐	☐	Iron	☐	☐	Probiotics	☐	☐	Vitamin D
☐	☐	Calcium	☐	☐	Marijuana	☐	☐	Recreational Drugs	☐	☐	Vitamin E
☐	☐	Corticosteroids	☐	☐	Melatonin	☐	☐	Sodium	☐	☐	Vitamin K
☐	☐	Fish Oil	☐	☐	Omega 3	☐	☐	St. Johns Wart	☐	☐	Wt. Loss Medicines
☐	☐	Folic Acid	☐	☐	Over-the-counter Medicine	☐	☐	Vitamin A	☐	☐	Zinc
☐	☐	Other									

(Please specify – include prescribed medications)

Allergies:

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Aspirin	☐	☐	Food	☐	☐	Latex	☐	☐	Penicillin
☐	☐	Barbiturates	☐	☐	Iodine	☐	☐	Local Anesthetic	☐	☐	Sulfa
☐	☐	Codeine	☐	☐	Other						

(Please specify below)

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Please review medical conditions below and answer based on current or past health history and answer accordingly.

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	AIDS/ HIV	☐	☐	Cosmetic Procedure	☐	☐	Headaches	☐	☐	Learning/ Development Challenges
☐	☐	Alzheimer's	☐	☐	Coughing Blood	☐	☐	Heart Disease	☐	☐	Respiratory Disease
☐	☐	Anemia	☐	☐	Diabetes	☐	☐	Heart Murmurs	☐	☐	Rheumatic Fever
☐	☐	Angina	☐	☐	Diarrhea or Constipation	☐	☐	Hepatitis Type A	☐	☐	Scarlet Fever
☐	☐	Arthritis	☐	☐	Diet Restrictions	☐	☐	Hepatitis Type B	☐	☐	Shortness of Breath
☐	☐	Artificial Heart Valve	☐	☐	Difficulty Urinating	☐	☐	Hepatitis Type C	☐	☐	Sinus Trouble
☐	☐	Artificial Joints	☐	☐	Dizziness	☐	☐	Herpes	☐	☐	Skin Rash
☐	☐	Asthma	☐	☐	Drug/Alcohol Abuse	☐	☐	High Blood Pressure	☐	☐	Sleep Apnea
☐	☐	Auto Immune Issues	☐	☐	Dry Mouth	☐	☐	Jaundice	☐	☐	Stroke
☐	☐	Back Problems	☐	☐	Ear Ringing	☐	☐	Jaw Pain	☐	☐	Swallowing Difficulty
☐	☐	Behavioral Challenges	☐	☐	Easy Bruising	☐	☐	Joint Pain/ Stiffness	☐	☐	Swollen Feet/ Ankles
☐	☐	Bleeding Abnormally	☐	☐	Eating Disorder	☐	☐	Kidney Disease	☐	☐	Swollen Neck Glands
☐	☐	Blood Disease	☐	☐	Emphysema, Lung Disease	☐	☐	Liver Disease	☐	☐	Thyroid Problems
☐	☐	Blood in Stool	☐	☐	Epilepsy/ Seizures	☐	☐	Low Blood Pressure	☐	☐	Tobacco Use
☐	☐	Blurred Vision	☐	☐	Excessive Thirst	☐	☐	Mitral Valve Prolapse	☐	☐	Tonsillitis
☐	☐	Blood in Urine	☐	☐	Fainting/ Dizziness	☐	☐	Nervous Disorder	☐	☐	Tuberculosis
☐	☐	Cancer	☐	☐	Fever	☐	☐	Night Sweats	☐	☐	Tumor or Growth (Head/Neck)
☐	☐	Chest Pain	☐	☐	Frequent Urination	☐	☐	Osteoporosis	☐	☐	Ulcer
☐	☐	Cholesterol	☐	☐	Frequent Vomiting	☐	☐	Pacemaker	☐	☐	Venereal Disease
☐	☐	C.O.P.D	☐	☐	GERD	☐	☐	Persistent Cough	☐	☐	Wear Contact Lenses
☐	☐	Circulatory Problems	☐	☐	Glaucoma	☐	☐	Psychiatric Care	☐	☐	Weight Change (Unexplained)
☐	☐	Congestive Heart Failure	☐	☐	Head Injury	☐	☐	Radiation Treatment			

Does anyone in your immediate family have a history if the following?

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Cancer	☐	☐	High Blood Pressure	☐	☐	High Cholesterol	☐	☐	Sleep Apnea
☐	☐	Diabetes									

For Women Only:

Yes	No			Yes	No	
☐	☐	Are you pregnant?	Due Date: _____	☐	☐	Are you taking ANY form of birth control?
☐	☐	Are you nursing?				

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potential medically compromising situation, a medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician

Print Name: _____ Signature: _____ Date: _____

Relationship to patient: (if applicable – please sign in office) _____

Update Contact Information: (if new or updated info only)

Phone: _____ Email: _____

Address: _____

City, State, Zip: _____

Office Use Only

Blood Pressure: _____ Dr. License No: _____

Pulse: _____

Alerts: _____