

# Sierra Dental Health History • Martin G. Williams, D.D.S.

Name \_\_\_\_\_ Occupation \_\_\_\_\_  
 SSN \_\_\_\_\_ Employed by \_\_\_\_\_  
 Address \_\_\_\_\_ Work Phone # \_\_\_\_\_  
 City \_\_\_\_\_ Zip Code \_\_\_\_\_ Name of Spouse \_\_\_\_\_  
 Phone # \_\_\_\_\_ Birthdate \_\_\_\_\_ Spouse SSN \_\_\_\_\_  
 Single  Married  Separated  Divorced  Widowed Spouse Employed by \_\_\_\_\_  
 Whom may we thank for referring you? \_\_\_\_\_ Spouse Birthdate \_\_\_\_\_  
 \* Who may we contact in case of an emergency? \_\_\_\_\_ Phone # \_\_\_\_\_

1. Medical Doctor \_\_\_\_\_

Date of last physical exam \_\_\_\_\_

2. Address \_\_\_\_\_

3. How would you describe your general health?

Good  Fair  Poor

4. Have you been sick or shown an allergy to:

Antibiotics (Penicillin, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sulfa	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Codeine	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Novocaine or other dental anesthesia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Other drugs or medications _____		

5. Are you now:

Pregnant  
 On a prescribed diet  
 Using thyroid  
 Using hormones (including birth control)  
 Using anticoagulants (blood thinners)  
 Using allergy medication  
 Using tranquilizers  
 Using dilantin  
 Medication for high blood pressure  
 Using other medication  
 Under a Psychiatric Care  
 Taking Vitamins/Supplements  
 Sensitive to Latex or Metals

6. Do you wear a pacemaker?  Yes  No

7. Do you use tobacco?  Yes  No  
 Cigarettes, cigar, pipe, chewing If yes, circle one.

8. Have you ever been prescribed an antibiotic before dental treatment for any of the following:

Rheumatic fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hip or joint replacement	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Condition	<input type="checkbox"/> Yes	<input type="checkbox"/> No

10. Please list medications you are currently using \_\_\_\_\_

11. Please note any other medical conditions not previously stated \_\_\_\_\_

I hereby state that the above information is correct and complete.

Signature \_\_\_\_\_ Date: \_\_\_\_\_

9. Have you ever had any of the following?

Heart disease or heart surgery  
 Heart murmur (mitral valve prolapse)  
 Pain, pressure in chest  
 Heart attack  
 Rheumatic fever  
 High blood pressure  
 Fainting spells, convulsions  
 Frequent headaches  
 Leukemia  
 Artificial joints  
 Stroke  
 Nervous breakdown  
 Lung trouble  
 Diabetes  
 Hepatitis, liver disease, jaundice  
 Kidney disorder  
 Arthritis, sore joints  
 Excessive bleeding  
 Blood disorder, anemia  
 VD (syphilis, gonorrhea)  
 Radiation Therapy  
 Cobalt treatments  
 Cancer  
 HIV Negative  
 HIV Positive  
 AIDS  
 Tuberculosis (TB)  
 Psychiatric Counseling  
 Serious Illness  
 Major Surgery  
 Asthma  
 Inhaler Dependent  
 Alcohol Dependent  
 Habitually use Controlled Substances  
 Stomach Problems  
 Broken Bones

I have reviewed the attached MEDICAL HISTORY. My (or the patient's) health and medications have changed as follows (if no change, write "No Change"):

\_\_\_\_\_

\_\_\_\_\_

BP \_\_\_\_\_ / \_\_\_\_\_

P \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient (or Guardian)

\_\_\_\_\_  
Date

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Signature of Patient (or Guardian)

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