NORTH POINT
DENTAL GROUP, LLC

PATIENT HEALTH HISTORY

Name: _____Who is your primary care physician?_____

Are you now taking any medications, drugs, or pills? ……YES NO

If yes, please list: _____

_____

Have you ever taken bone density drugs (bisphosphonates)? Examples: Boniva, Fosamax, Reclast, Actonel, Didronal, Skelid……..YES NO

Are you aware of being allergic to, or have you ever reacted adversely to any medication or substance?.....YES NO

If yes, please list: _____

Do you have any bleeding disorder, or are you taking any blood thinning medications? …… YES NO

Indicate which of the following you have had or have at present:

Heart (Disease, Attack, Surgery)..	YES	NO	Kidney Problems……	YES	NO	Special Diet……	YES	NO
Shortness of breath……	YES	NO	Ulcers……	YES	NO	Unexplained Weight change….	YES	NO
Congenital Heart Disease……	YES	NO	Diabetes……	YES	NO	Hepatitis (A, B or C, which)……	YES	NO
Heart Murmur……	YES	NO	Thyroid Problems……	YES	NO	Immunocompromised……	YES	NO
High Blood Pressure……	YES	NO	Emphysema……	YES	NO	Blood Transfusion……	YES	NO
Arteriosclerosis……	YES	NO	Chronic Cough……	YES	NO	Hemophilia……	YES	NO
Mitral Valve Prolapse……	YES	NO	Tuberculosis/PPD Positive……	YES	NO	Anemia……	YES	NO
Artificial Heart Valve……	YES	NO	Asthma……	YES	NO	Liver Disease……	YES	NO
Heart Pacemaker……	YES	NO	Hay Fever……	YES	NO	Epilepsy or Seizures……	YES	NO
Rheumatic Fever……	YES	NO	Latex Allergy……	YES	NO	Fainting or Dizzy Spells……	YES	NO
Arthritis……	YES	NO	Sinus Problems……	YES	NO	Nervousness……	YES	NO
Drug Addiction, Alcoholism……	YES	NO	Cancer or Tumor……	YES	NO	Psychiatric Treatment……	YES	NO
Current Tobacco Use……	YES	NO	Radiation Therapy……	YES	NO	Glaucoma……	YES	NO
Artificial Joints (hip, knee, etc.)….	YES	NO	Chemotherapy……	YES	NO	Stroke……	YES	NO

Do you have or have you had any diseases, condition, or problem not listed?.....YES NO

If yes, please list: _____

Have you been hospitalized in the last two years?.....YES NO

Women: Are you…… Pregnant: ☐ YES ☐ NO Nursing: ☐ YES ☐ NO Taking birth control pills? ☐ YES ☐ NO

Have you been told, or are you aware that you clench or grind your teeth? ☐ Day ☐ Night……YES NO

Is your jaw or are your teeth tired when you awaken, or do you ever experience jaw pain?..... YES NO

Are you happy with the appearance of your teeth? (color, size, shape, alignment)…… YES NO

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency. I will notify the dentist of any health or medication changes. I authorize x-rays, oral exams, study models, photographs, and any other diagnostic aids deemed appropriate to make a thorough dental diagnosis. I authorize treatment, medication, and therapy that may be indicated. I understand there is a very low risk of nerve damage in the mouth from the administration and use of local anesthetics.

_____

Signature of Patient or Guardian Date