



HEALTH HISTORY

Patient Name _____ Date ____/____/____

The thoroughness of this medical history is designed for your safety. Your complete answers will assist us in treating you with every consideration for your specific needs. This information is confidential.

Name of personal physician _____ Phone #: _____

How do you assess your current health? Excellent Good Fair Poor

Are you currently under the care of a physician? Yes No

If yes, please explain: _____

Have you been hospitalized or had any serious medical problems within the past 5 years? Yes No

If yes, please explain: _____

- | | |
|---|---|
| <input type="checkbox"/> Angina (chest pains) Frequency _____ | <input type="checkbox"/> Rheumatic Fever (date) _____ |
| <input type="checkbox"/> Heart attack (date) _____ | <input type="checkbox"/> Heart murmur/mitral valve prolapse |
| <input type="checkbox"/> Heart surgery (date) _____ | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Stroke (date) _____ |
| <input type="checkbox"/> Bypass | <input type="checkbox"/> Other |
| <input type="checkbox"/> Prosthetic heart valve | |

Have you ever had or been treated for any of the following diseases or medical conditions? (please check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Hepatitis/Jaundice | <input type="checkbox"/> Abnormal bleeding |
| <input type="checkbox"/> Epilepsy/Seizures/Fainting | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Cancer/Chemotherapy | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Psychiatric problems | <input type="checkbox"/> Asthma or lung disease |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hip or other joint replacement |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Drug/Alcohol abuse | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Glaucoma |

Have you been treated for any other illnesses not listed above? Yes No If yes, please explain:

Are you allergic to any of the following medications? (please check all that apply)

- | | |
|---------------------------------------|--|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Dental Anesthetic |
| <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Aspirin |

Are you allergic to any other pain medications or antibiotics? Yes No If yes, please list:



THOMAS FRANK, DDS
COSMETIC IMPLANT LASER DENTISTRY

Have you ever been advised to take antibiotics before dental treatment? Yes No

Are you currently taking prescription medications? (If yes, please list below) Yes No

Name of Medication

Purpose

Name of Medication	Purpose

Do you use "Recreational" drugs? Yes No

"Recreational" drugs such as cocaine, marijuana, stimulants or depressants (prescription and over-the-counter) may have dangerous interactions with local anesthetics or other common dental medications. Please describe the use of any drugs or discuss in complete confidentiality with the doctor.

Women: Are you pregnant? (Expected delivery date _____) Yes No

Women: Are you taking birth control pills? Yes No
(Certain antibiotics may adversely interact with oral contraceptives)

NOTES:

Patient's B.P. is _____

Date: _____

Med. Hx. Rev. (int'l) _____

Date: _____

To the best of my knowledge, all the preceding answers are true and correct. If I have any change in my health or medications, I will inform the doctor. If deemed advisable, I grant permission for my physician to be contacted for details and advise. I further authorize the taking of radiographs, photographs, or other diagnostic measures appropriate for a thorough evaluation. Authorization is also given for dental treatment to be rendered by the doctor and office staff. I also give permission for the doctor or his staff to use any photos he may take to be used for lecturing or educational purposes. I understand that I am financially responsible for all treatment rendered, regardless of insurance involvement.

Signature of Patient or Guardian (if patient is a minor)

Date