Beach Heights Dentistry Patient Medical History

Patient Name_____DOB_____
Medical Alert & Allergies (Office Use Only)_____
Physician's Name _____ Phone _____ Last Exam_____

Have you had or been tested for COVID-19? Yes or No Date of test:_____ Your test result Positive or Negative Date of Test:_____
Have you been tested for COVID19 antibodies? Yes or No Your test results IgG IgM IgG/IgM Date of Test:_____

1. Have you had any medical care within the past two years?_____ Yes ____ No ____
   If yes, please explain_____
2. Have you been admitted to a hospital or needed emergency care during the past two years? Yes ____ No ____
   If yes, please explain_____
3. Are you under the care of a Physician? Yes ____ No ____
   If yes, please explain_____
4. Have you taken bone loss prevention drugs (Fosamax, Actonel, Boniva or other similar drugs)? Yes ____ No ____
5. Do you smoke, vape or use tobacco products? How often _____ Product _____
6. History of eating disorder? Please explain_____ Yes ____ No ____
7. Have you ever had any complications during or following dental treatment? Yes ____ No ____
   If yes, please explain_____
8. Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin? Yes ____ No ____
   If yes, please list_____
   _____
9. Are you aware of having an allergic (or adverse) reaction to any substance or medication? Yes ____ No ____
10. Are you aware of any sleep disorder? If yes, please explain_____ Yes ____ No ____
    If yes, please explain_____
11. Indicate which of the following you have had, or have at the present. Please, circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	Yes	No	Latex Sensitivity	Yes	No	Hemophilia/bleeding disorder	Yes	No
COVID-19	Yes	No	Cancer	Yes	No	Epilepsy or Seizures	Yes	No
Artificial Heart Valve/Pacemaker	Yes	No	Hay Fever/Allergies/Sinus	Yes	No	Fainting or Dizzy Spells	Yes	No
High/Low Blood Pressure	Yes	No	Alzheimer	Yes	No	Psychiatric/Psychological Care	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Tuberculosis	Yes	No	Neurological Disorders	Yes	No
Kidney Issues	Yes	No	Radiation/Chemotherapy	Yes	No	Anemia	Yes	No
Liver Disease/Yellow Jaundice	Yes	No	Cannabis THC CBN CBD (circle)	Yes	No	Pregnancy Due_____	Yes	No
Respiratory Issues/Asthma/COPD	Yes	No	Tumors/Ulcers	Yes	No	Neck or Back Issues	Yes	No
Diabetes	Yes	No	Hepatitis A B C (circle)	Yes	No	Snore/Sleep apnea	Yes	No
Thyroid Issues	Yes	No	STDs	Yes	No	Cold Sores/Fever Blisters	Yes	No
Stroke.	Yes	No	A.I.D.S./H.I.V Positive	Yes	No	Arthritis/Rheumatism	Yes	No

12. Do you have or have you had any disease, condition or problem not listed? Yes ____ No ____
    If yes, please explain_____

DENTAL HISTORY

1. Any current dental issues you want us to address? _____
2. Are you happy with your smile? _____
3. Date of Last Dental Visit _____ Please, tell us about your visit? _____
4. Previous Dentist Name _____ Phone _____
5. Dental History: Oral Surgery _____ Periodontal History _____ Ortho/Braces _____ Endo/Root Canal _____ Prosthodontist _____
6. Have you ever been told to take pre-medication prior to dental treatment? Yes ____ No ____
7. Is there anything else about having dental treatment that you would like us to know? Yes ____ No ____
   If yes, please explain _____

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, who may release such information to you. If I ever have any change in my health or medications, I will inform the doctor and/or dental hygienist at the next appointment without fail.

Patient/Guardian Signature _____ Date: _____
(Office Use Only) Notes: _____ Form by SLS RDH
Reviewed by: _____ Date: _____