HEYS DENTAL
EST 1972

Patient Health Record

Physician's Name: _____ Phone: _____

Are you under a physician's care now? ☐ YES ☐ NO

If **YES**, reason _____

Date of LAST DENTAL visit: _____

List any medications you are currently taking (if none, please print none)

MEDICATIONS	REASON FOR TAKING
_____	_____
_____	_____
_____	_____
_____	_____

Are you allergic to any of the following? Please check those that apply.

☐ Aspirin ☐ Latex ☐ Sulfa
☐ Codeine ☐ Local Injected Anesthetic ☐ Other Drugs
☐ Iodine ☐ Penicillin ☐ Nuts

If other, please list _____

Do you bleed easily? ☐ YES ☐ NO

Have you ever had radiation therapy? ☐ YES ☐ NO

Are you taking any Bisphosphonates? ☐ YES ☐ NO If yes, how long? _____

(Examples: Fosamax, Boniva, Actonel, Zometa)

Women, are you pregnant? ☐ YES ☐ NO

Have you ever had any of the following? Please check those that apply.

☐ AIDS
☐ Asthma
☐ Blood Disorder
☐ Cancer
Type _____
Date _____
☐ Diabetes
☐ Dialysis Shunt
☐ Epilepsy
☐ Glaucoma
☐ Hearing Loss
☐ Liver Disease

Heart Problems
☐ Angina
☐ Bypass Surgery
Date _____
☐ Congenital Heart Def
☐ Coronary Angioplasty
☐ Heart Attack
Date _____
☐ Other _____

☐ Heart Murmur
☐ Mech Heart Valve
☐ Mitral Valve Prolapse
☐ Open Heart Surgery
Date _____
☐ Pacemaker
Date placed _____

☐ Hepatitis
☐ Herpes
☐ High Blood Pressure
☐ Prosth Joint Replacement
Type _____
Date _____
☐ Stroke
☐ Thyroid Trouble
☐ Tobacco Use
☐ Tuberculosis
☐ Venereal Disease

☐ Other _____

SIGNATURE _____ **DATE** _____