DENTAL ARTS CENTER

Jonathan E. Beaugez, D.M.D.
IMPLANTS.GENERAL.COSMETIC

HEALTH HISTORY FORM

Patient Name: _____ Birth Date: _____
Last First mm/dd/yyyy

Do you or have you experienced the following?

Heart Attack	☐Y	☐N	Fainting Spells	☐Y	☐N
Heart Disease	☐Y	☐N	Epilepsy	☐Y	☐N
Heart Murmur	☐Y	☐N	Seizures	☐Y	☐N
Heart Surgery	☐Y	☐N			
Heart Pacemaker	☐Y	☐N	Diabetes	☐Y	☐N
Heart transplant	☐Y	☐N	High Blood Pressure	☐Y	☐N
Previous Endocarditis	☐Y	☐N	Low Blood Pressure	☐Y	☐N
Prosthetic Heart Valve	☐Y	☐N	High Cholesterol	☐Y	☐N
Mitral Valve Prolapse	☐Y	☐N	Thyroid Problems	☐Y	☐N
Artificial Joint	☐Y Date:	☐N	Osteoporosis	☐Y	☐N
Cancer	☐Y	☐N	Arthritis	☐Y	☐N
Liver Disease	☐Y	☐N		☐Y	☐N
Kidney Disease	☐Y	☐N	Emphysema	☐Y	☐N
Hepatitis	☐A Infectious ☐B Serum ☐C		Chronic Cough	☐Y	☐N
Tuberculosis	☐Y	☐N	Asthma	☐Y	☐N
Psychiatric Treatment	☐Y	☐N	Sinus Problems	☐Y	☐N
Anxiety	☐Y	☐N	Cold Sores	☐Y	☐N
Drug Addiction	☐Y	☐N	Headaches	☐Y	☐N
Alcohol Abuse	☐Y	☐N	Stroke	☐Y	☐N
AIDS	☐Y	☐N	Anemia	☐Y	☐N
HIV	☐Y	☐N	Ulcers	☐Y	☐N
Blood Transfusion	☐Y	☐N	Bruise Easily	☐Y	☐N

Are you allergic to any of the following?

Aspirin	☐Y	☐N	Gluten	☐Y	☐N	Sedatives	☐Y	☐N
Barbiturates	☐Y	☐N	Jewelry	☐Y	☐N	Sulfa Drugs	☐Y	☐N
Codeine	☐Y	☐N	Latex	☐Y	☐N	Tetracycline	☐Y	☐N
Dental Anesthetics	☐Y	☐N	Nuts	☐Y	☐N	Other:	☐Y	☐N
Erythromycin	☐Y	☐N	Penicillin	☐Y	☐N	_____		

Please list additional foods or drugs that cause allergic reactions:

_____

_____

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Name of your physician: _____

Physician's Location: _____

Physician's Phone Number: _____

Are you currently taking any prescribed medications? (Please list all) (If none, please write "none"):

1. _____ 2. _____ 3. _____ 4. _____
5. _____ 6. _____ 7. _____ 8. _____

Do you or have you experienced the following?

Are you currently in pain?	☐Y	☐N	
Do you need to take antibiotic prior to dental treatment?	☐Y	☐N	
Are you subject to prolonged bleeding?	☐Y	☐N	
Do you use tobacco?	☐Y	☐N	
Are you pregnant?	☐Y	☐N	
Have you had problems with previous dental treatment?	☐Y	☐N	
Do you gag easily?	☐Y	☐N	
Do your gums bleed when you brush?	☐Y	☐N	
Do your gums bleed when you floss?	☐Y	☐N	
Are your teeth sensitive to hot or cold?	☐Y	☐N	
Are you happy with how your smile look?	☐1x	☐2x	☐3x
How often do you brush per day?	☐Soft	☐Medium	☐Hard
Type of bristles on your toothbrush	☐1x	☐2x	☐3x
How do you often floss per week?	☐Y	☐N	
Do you use anything else in addition to your brush and floss?	☐Y	☐N	

Please list any other medical conditions not mentioned on this for that Dr. Beaugez should know about:

_____

_____

By checking this box ☐ and signing below, I acknowledge and understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____ _____

Signature **Date**