Charles Drew HEALTH CENTER, INC.

Dental Health History Form

Section 1: Patient Information

First name: _____ Last name: _____ Middle initial: _____

Sex assigned at birth: _____ Birth date: _____ Age: _____

Please select one answer per question and provide additional information when required:

Are you in good health?	☐ Yes	■ No
Have there been any recent changes in your health?	☐ Yes	■ No
Date of last physical exam: _____		
Are you under a physician's care for any problems?	☐ Yes	☐ No
Have you ever had any serious illnesses, operations, or hospitalizations?	☐ Yes	☐ No

FOR WOMEN PATIENTS ONLY:

Are you pregnant or is there any chance you could be?	☐ Yes	☐ No
Are you nursing?	☐ Yes	☐ No
Are you taking oral contraceptives?	☐ Yes	☐ No

Are you taking any of the following:

Antibiotics?	☐ Yes	☐ No
Anticoagulants (blood thinners)?	☐ Yes	☐ No
Antidepressants?	☐ Yes	☐ No
Cortisone (steroids)?	☐ Yes	☐ No
Medicine for high blood pressure?	☐ Yes	☐ No
Aspirin?	☐ Yes	☐ No
Insulin or diabetic drugs?	☐ Yes	☐ No
Fosamax or biophosphonate?	☐ Yes	☐ No
Are you taking other drugs or medications?	☐ Yes	☐ No

If **yes**, which drugs/medication and how much: _____

_____

Are you allergic or have you adversely reacted to any of the following:

Latex?	☐ Yes	☐ No
Local anesthetic?	☐ Yes	☐ No
Penicillin/antibiotics?	☐ Yes	■ No
Metals?	☐ Yes	☐ No
Pain medication?	☐ Yes	☐ No
Other: _____		

Please indicate any history of the following:

Heart surgery or artificial heart valve	☐ Yes	☐ No
Congenital heart defect	☐ Yes	☐ No
Heart attack	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
High/low blood pressure	☐ Yes	☐ No
Artificial joint (hip, knee) implants, prosthesis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Persistent or bloody cough	☐ Yes	☐ No
Tobacco Use	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Radiation treatment to head or neck region	☐ Yes	☐ No
Any bleeding conditions or disorders	☐ Yes	☐ No
Fainting spells or seizures	☐ Yes	☐ No
Osteoporosis	☐ Yes	☐ No
Hepatitis or jaundice	☐ Yes	☐ No
Kidney problems	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Mental health issues	☐ Yes	☐ No
Do you have any other medical conditions?	☐ Yes	☐ No

If yes, please explain: _____

I understand the importance of a truthful and complete Health History to assist my dentist in providing the best care possible. If there are any changes in my health, or medicines, I will inform my dentist at my next appointment.

Patient or Guardian's Signature: _____ Date: _____

Interpreter's Name AND Signature: _____ Date: _____