BLOOMVALEDENTAL

BloomvaleDental.com
5337 Hamner Ave Unit 707
951-325-4600

Health History Form

Date_____

Please circle (Y) for "yes", or (N) for "no" for any of the following which may apply to you now, or in the past:

Y N Heart Attack or Trouble
Y N Congenital Heart Disease
Y N Drug/Alcohol Dependency
Y N High Blood Pressure
Y N Heart Valve Disorder
Y N Psychiatric Disorders
Y N Implant or Artificial Joint
When? _____

Y N Exercise Chest Pain (angina)
Y N Asthma
Y N Anemia or Blood Disorder
Y N Excessive Bleeding
Y N Headaches or Migraines
Y N Tumors, Cancer, Radiation
Y N Tuberculosis, Lung Problem

Y N Thyroid Disease
Y N Epilepsy or Seizures
Y N Ulcers, Reflux, Heartburn
Y N Digestive Disorders
Y N Kidney Problems
Y N AIDS or HIV Infection

Y N Diabetes
Y N Fainting or Blackouts
Y N Stroke
Y N Pacemaker
Y N Hepatitis A B C D
Y N Use Tobacco

Periodontal disease has been linked to the following, do you have any family history of: (circle any that apply)

Heart Disease Stroke Diabetes Early-Term Birth Cancer Dementia

Are you currently pregnant?_____ If yes when are you expecting?_____

Have you seen a physician or been hospitalized in the last two years (including pregnancy)? Y N

If yes, please explain _____

Physician's name and phone:_____

Are you ALLERGIC to or have you reacted adversely to the following?

☐ Antibiotics ☐ Aspirin ☐ Codeine

☐ Latex ☐ Metals/Jewelry ☐ Local/Dental Anesthetic

Are you aware of being allergic to any other medications or substances? If yes, please list:

_____

_____

Please list any prescription or over the counter drugs, medications, or vitamins you are currently taking:

_____

_____

_____

Responsible Party Signature:_____ Date:_____

Doctor/Hygienist Signature:_____ Date:_____