Copper Country Family Dentistry P.C.

PATIENT HISTORY
(CONFIDENTIAL)

Patient Name________________________ Birthdate__________ Today's Date__________
LAST FIRST INITIAL

MEDICAL HISTORY

Physician's Name________________________ Date of Last Visit__________

Have you had any serious illnesses or operations? ☐ Yes ☐ No If Yes,Describe:________________

Have you been hospitalized in the last 5 years? ☐ Yes ☐ No If Yes, Describe:________________

Have you been advised to take medication prior to dental visits? ☐ Yes ☐ No

WOMEN: Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking Birth Control Pills? ☐ Yes ☐ No

Cardiovascular
- Heart failure or disease ☐ Yes ☐ No
- Heart surgery ☐ Yes ☐ No
- Heart attack ☐ Yes ☐ No
- Angina (chest pain) ☐ Yes ☐ No
- High blood pressure ☐ Yes ☐ No
- Heart infection ☐ Yes ☐ No
- Congenital heart problem ☐ Yes ☐ No
- Stroke ☐ Yes ☐ No
- Other vascular problem ☐ Yes ☐ No

Hematologic
- Anemia ☐ Yes ☐ No
- Abnormal bleeding or bruising ☐ Yes ☐ No

Musculoskeletal
- Artificial joint (hip, knee, etc.) ☐ Yes ☐ No
- Arthritis / rheumatism ☐ Yes ☐ No
- Osteoporosis ☐ Yes ☐ No
- Fibromyalgia ☐ Yes ☐ No
- Lupus ☐ Yes ☐ No
- Sjogren's Syndrome ☐ Yes ☐ No

Respiratory
- Asthma ☐ Yes ☐ No
- Bronchitis or Emphysema ☐ Yes ☐ No
- Chronic cough ☐ Yes ☐ No

Cancer
- Cancer / tumors ☐ Yes ☐ No
- Chemo- or radiation therapy ☐ Yes ☐ No

Gastrointestinal (GI)
- Acid Reflux (GERD) ☐ Yes ☐ No
- Stomach ulcer ☐ Yes ☐ No
- Diet (special / restricted) ☐ Yes ☐ No

Immune
- Delayed healing ☐ Yes ☐ No
- HIV positive / AIDS ☐ Yes ☐ No

Endocrine
- Diabetes ☐ Yes ☐ No
- Thyroid problems ☐ Yes ☐ No

Eyes / Ears
- Glaucoma ☐ Yes ☐ No
- Impaired vision ☐ Yes ☐ No
- Impaired hearing ☐ Yes ☐ No

Neurologic
- Epilepsy / seizures ☐ Yes ☐ No
- Fainting / dizzy spells ☐ Yes ☐ No
- Headaches ☐ Yes ☐ No

Mental Health
- Psychiatric / psychological care ☐ Yes ☐ No
- Dementia ☐ Yes ☐ No
- Anxiety ☐ Yes ☐ No
- Eating disorder ☐ Yes ☐ No
- Sleep disorder ☐ Yes ☐ No

Other
- Hay fever ☐ Yes ☐ No
- Allergies ☐ Yes ☐ No
- Sinus trouble ☐ Yes ☐ No
- Cold sores ☐ Yes ☐ No
- Sexually transmitted disease ☐ Yes ☐ No
- Hepatitis (type_____) ☐ Yes ☐ No
- Other liver disease ☐ Yes ☐ No
- Kidney disease ☐ Yes ☐ No
- Chemical dependency ☐ Yes ☐ No
- Tobacco use (smoke / chew) ☐ Yes ☐ No

Do you have, or have you had any disease, condition, or problem not listed? ☐ Yes ☐ No

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MEDICATIONS

List medications you are currently taking:________________

Doctor's Comments:________________

ALLERGIES

- Aspirin ☐ Yes ☐ No
- Barbiturates (Sleeping Pills) ☐ Yes ☐ No
- Codeine/Pain Medication ☐ Yes ☐ No
- Latex ☐ Yes ☐ No
- Metals ☐ Yes ☐ No
- Penicillin ☐ Yes ☐ No
- Sulfa ☐ Yes ☐ No
- Local Anesthetic (Novocaine) ☐ Yes ☐ No
- Other__________ ☐ Yes ☐ No

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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. I will notify the doctor(s) of any change in my health or medication.

Patient (Parent or Guardian) Signature________________________ Date__________

Doctor Signature________________________ Date__________

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PATIENT NAME	HEALTH HISTORY UPDATE
Date:	Current Medications
Health Changes:	1. 5.
	2. 6.
	3. 7.
	4. 8.
Patient Signature:	Doctor Initials
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Health Changes:	1. 5.
	2. 6.
	3. 7.
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