Southern Smiles
FAMILY & COSMETIC DENTISTRY
Patrick S. Burchfield DDS & Gregory M. Melton DDS

Patient Health History

Name ____________________________ Date of birth __________________

ASA ___ Circle Answer

1. Are you receiving any **medical treatment** now? Yes or No

If Yes, please explain what you are being treated for and list your doctor's name and phone number: ____

2. Please list **any medication(s)** that you are currently taking and their **purpose:**

____

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3. Are you **allergic to** any medications/anesthetics/latex? Yes or No

If Yes, please list: ____

4. Has a physician ever informed you that you have

- a. Any heart ailment (heart attack, heart murmur, angina pectoris)………..Yes or No
- b. High Blood pressure……………………………………………..…Yes or No
- c. Diabetes……………………………………………………….……Yes or No
- d. Lung disease or asthma…………………………………...…...Yes or No
- e. Rheumatic fever…………………………………………….....Yes or No
- f. Hepatitis or liver disease...…………………………………......Yes or No
- g. Any blood disease (sickle cell, hemophilia)……………………….....Yes or No
- h. Kidney disease……………………………………………….....Yes or No
- i. Glaucoma…………………………………………………………Yes or No
- j. Any bleeding tendency (bruise easily)………………………….....Yes or No
- k. Tuberculosis……………………………………………………....Yes or No
- l. Sexually transmitted disease (HIV/AIDS, herpes, syphilis, gonorrhea)….Yes or No
- m. Cancer (radiation or chemotherapy?)……………………………Yes or No
- n. Mental health disorder……………………………………………Yes or No
- o. Thyroid problems…………………………………………………Yes or No
- p. Osteoporosis………………………………………………………Yes or No
- q. Artificial heart valve, artificial joint, or pacemaker………....……..Yes or No
- r. Epilepsy or seizures………………………………………………..Yes or No
- s. Allergies (hay fever, sinus trouble, hives)…………………………………..Yes or No
- t. Stroke………………………………………………………………Yes or No
- u. Drug/alcohol addiction……………………………………………Yes or No

If you answered Yes above, please add pertinent information or explain any other medical conditions not listed above:____

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5. Have you **been ill, had surgery, or been hospitalized** recently? Yes or No

If Yes, please explain and supply date(s) _______________________________________

6. Have you ever fractured your jaw? Yes or No

7. (Women) Are you **pregnant or nursing**? Yes or No

9. Has a physician or previous dentist recommended that you take **antibiotics prior to your dental treatment**? Yes or No If Yes, what antibiotic and dose? _______________

10. Do you **use tobacco** products? Yes or No If yes, type/frequency? _______________

11. What is your preferred **pharmacy and location**? ____________________________

My medical history is complete and accurate

Patient Signature ________________________ Date _____________

__________ __________ __________ __________ __________ __________

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