Shandrick
Dental Care Studios
ROBERT S. SHANDRICK DMD, FAGD
exceptional dentistry for exceptional smiles

5 HEALTH HISTORY

Physician's Name: _____ Date of Last Visit:_____

	Yes	No
AIDS / HIV	☐	☐
ANEMIA	☐	☐
Arthritis, Rheumatism	☐	☐
*Artificial Heart Valves	☐	☐
*Artificial Joints	☐	☐
Asthma	☐	☐
Back Problems	☐	☐
Bleeding abnormally, with extractions or surgery	☐	☐
Blood Disease	☐	☐
Cancer	☐	☐
Chemical Dependency	☐	☐
Chemotherapy	☐	☐
Circulatory Problems	☐	☐
Congenital Heart Lesions	☐	☐
Cortisone Treatments	☐	☐
Cough, persistent or bloody	☐	☐
Diabetes	☐	☐
Emphysema	☐	☐
Epilepsy	☐	☐
Fainting or Dizziness	☐	☐
Glaucoma	☐	☐
*Heart Murmur	☐	☐
Heart Problems	☐	☐
Hepatitis Type _____	☐	☐
Herpes	☐	☐
High Blood Pressure	☐	☐
Jaundice	☐	☐
Jaw Pain	☐	☐
Joint Replacement	☐	☐
Kidney Disease	☐	☐
Liver Disease	☐	☐
Low Blood Pressure	☐	☐
*Mitral Valve Prolapse	☐	☐
Nervous Problems	☐	☐
*Pacemaker	☐	☐
Psychiatric Care	☐	☐
Radiation Treatment	☐	☐
Respiratory Disease	☐	☐
*Rheumatic Fever	☐	☐
Scarlet Fever	☐	☐
Shortness of Breath	☐	☐
Sinus Trouble	☐	☐
Skin Rash	☐	☐
Special Diet	☐	☐
Stroke	☐	☐
Swollen Feet or Ankles	☐	☐
Swollen Neck Glands	☐	☐
Thyroid Problems	☐	☐
Tonsillitis	☐	☐
Tuberculosis	☐	☐
Tumor or Growth on Head or Neck	☐	☐
Ulcer	☐	☐
Venereal Disease	☐	☐
Others	☐	☐

Comments: _____

_____

_____

_____

If yes to any of the starred conditions, please call prior to your appointment . . . Premedication may be required.

	Yes	No
Do you use tobacco products?	☐	☐
If yes, what and how often? _____		
Do you use antidepressants or sleeping pills?	☐	☐
If yes, list name(s) _____		
_____		
Have you ever been hospitalized for any surgical operations or serious illness within the last 5 years?		
If yes, please explain _____		
_____		
Are you on any blood thinners, including aspirin?	☐	☐
If yes, what? _____		

Women:

	Yes	No
Are you pregnant?	☐	☐
If yes, when is your due date?		
_____		
Taking birth control pills?	☐	☐
Are you taking hormones?	☐	☐

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

_____

Pharmacy Name: _____

Phone: (_____) _____

ALLERGIES

☐ No Allergies
☐ Aspirin
☐ Barbiturates (sleeping pills)
☐ Codeine
☐ Iodine
☐ Latex
☐ Local Anesthetic
☐ Penicillin
☐ Sulfa
☐ Other _____

_____

_____

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and team at the next appointment without fail.

Patient (Responsible Party) Signature **X** _____ Date_____

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