DAVID HONE DDS dentistry

MEDICAL & DENTAL HISTORY

Phone: 509.534.2666 • Fax: 509.534.1392 • Website: www.drhone.com • Thank you for completing this confidential information.

Patient Name _____ Medical Doctor _____

Please ask if you have any questions about how this information relates to your dental care.

Yes No Are you under medical treatment at this time?

Yes No Are you taking any medications regularly?
If so, please list

_____

_____

Yes No Treatment for osteoporosis (fosamax)
Yes No Do you take any herbal supplements or vitamins?
Yes No Have you ever used or are you currently using tobacco?
How often per day? _____
Start/Quit date? _____
Yes No Would you like to stop?
Yes No Have you had any major operations?
If so, please list

_____

_____

Have you had an allergic reaction to:

Yes No Penicillin or other antibiotics
Yes No Latex
Yes No Metals, such as nickel, copper or tin
Yes No Anesthetics or novocaine
Yes No Aspirin
Yes No Sulfa drugs
Yes No Are you allergic to any other medications or substances?
If so, please list.

_____

_____

Women only:

Yes No Are you pregnant? Due date _____
Yes No Taking birth control pills or other hormones?

Do you have or have you had:

Yes No Psychiatric or anxiety disorder
Yes No Sinus trouble
Yes No Tuberculosis
Yes No Stroke
Yes No Heart trouble
Yes No High or low blood pressure
Yes No Artificial heart valve
Yes No Mitral valve prolapse or heart murmur
Yes No Diabetes Insulin dependent? Yes No
Yes No Epilepsy/Seizures
Yes No Antibiotics before dental treatment? Why? _____
Yes No Pacemaker
Yes No Emphysema
Yes No Asthma or other breathing problems
Yes No Hepatitis or other liver problems Type? _____
Yes No Kidney problems
Yes No Arthritis
Yes No Bleeding problems or anemia
Yes No HIV positive
Yes No Organ transplant
Yes No Chest pain (Angina)
Yes No Thyroid problems
Yes No Unresolved stress
Yes No Artificial joint, plate or shunt
Yes No Radiation treatment or chemotherapy
Yes No Cancer or tumor
Yes No Dry Mouth
Yes No Any other medical condition? If so, please list

_____

_____

What are your goals in terms of your oral health? _____

_____

What is your most important dental concern at this time? _____

To the best of my knowledge, I have answered every question completely and accurately. I hereby authorize Dr. Hone to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.

Patient's signature: _____ ☐ Adult patient ☐ Parent/Guardian Date: _____

I have reviewed my health history and discussed my changes.

Recall Review:	**Comments:**	**Date**	**Reviewed by**
Patient's signature: _____	_____	_____	_____
Patient's signature: _____	_____	_____	_____
Patient's signature: _____	_____	_____	_____