Portale Dental Health History

Name ____ Date ____________________

Date of last health care exam:________________ What was this exam for?________________________________

Have you been hospitalized in the last 5 years? ❒No ❒Yes

If yes, reason: ____

Are you currently receiving care? ❒ No ❒Yes If yes, nature of care:_______________________________

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. ____
2. ____
3. ____
4. ____

For the following questions, circle Yes or No. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health. *(please circle)*

Heart Murmur (mitral valve prolapse)	No	Yes	Psychosis	No	Yes
Anemia	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Previous biopsies	No	Yes
Epilepsy	No	Yes	Slow-Healing Mouth sores	No	Yes
Hepatitis, Any Form	No	Yes	Other Infections	No	Yes
Rheumatic Fever	No	Yes	Recurrent Illnesses	No	Yes
Asthma	No	Yes	Joint replacement	No	Yes
HIV Positive or AIDS Related Complex	No	Yes	Glaucoma	No	Yes
Emphysema or other Respiratory Illnesses	No	Yes	Abnormal Bleeding from a cut	No	Yes
Abnormal Heart Condition	No	Yes	Liver Disease (including Jaundice)	No	Yes
Kidney Disease	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart (Surgery, Disease, Attack)	No	Yes	Latex Sensitivity	No	Yes
Venereal Disease	No	Yes	**Other**:		

Are you required to Pre-Medicate before dental treatment? (Rx:__________________________) . . . . . . No Yes

Women: Are you pregnant? . . . . No Yes

If no, are you planning a pregnancy in the near future? . . . . No Yes

Are you a nursing mother? . . . . No Yes

Are you taking birth control pills? . . . . No Yes

Abnormal Blood Pressure? . . . . No Yes

If yes, what is it usually: S__________ / D__________

Are you allergic or have you had a reaction to:

a. Local anesthetics . . . . No Yes

b. Penicillin or other antibiotics . . . . No Yes

c. Aspirin . . . . No Yes

d. Codeine, valium or other sedatives . . . . No Yes

e. Other______________________________

Are you a smoker?. . . . . No Yes

If so, how much do you smoke per day?

Please list any medications you are currently taking:

1. ______________________ 2. ______________________
3. ______________________ 4. ______________________
5. ______________________ 6. ______________________

Are you taking Tagamet (Cimetidine)? No Yes If yes, how often? ______________________

Do you take Antacids? No Yes If yes, how often? ______________________

Are you taking herbal supplements/medications? ❐No ❐Yes If yes, which ones? ______________________________

Diet: Restricted Diet ______________________________
How many meals a day ______________________________
Food Allergies ______________________________
Sugar in your diet: ❐None ❐ Slight ❐Moderate ❐High

Headaches, TMJ pain:

Severe Migranes: 15 days/month, 4 hrs minimum? ______________________________

Occasional or Mild Migrane headaches? ______________________________

TMJ pain: __________________Do you use a Night Guard?______________________________

Have you received any Botox or Dermal Fillers in the past?______________________________

Any other issues regarding your medical or dental history:

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____

Dental management special requests:

____

______________________	______________________	______________
Patient (Print Name)	Patient Signature	Date
______________________	______________________	______________
Doctor (Print Name)	Doctor Signature	Date