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:

_____

_____

Dental management special requests:

_____

_____	_____	_____
Patient (Print Name)	Patient Signature	Date
_____	_____	_____
Doctor (Print Name)	Doctor Signature	Date

Submit