David A. Dischler, D.D.S., P.C.

Patient Information and Health History

Date ______________________________

Patient's Name ____Date of Birth________________________

Single Married Divorced Separated Widowed

Address ________________________________City _________________________ Zip _______Phone ________________

Person and address responsible for account ____

Email Address ____

Employed by____ Business phone________________________________

Business address _______________________________________ Patient's SS#__________________________________

Dental Insurance (if any) _________________________________ Referred by ___________________________________

Name of Primary Insured _______________________________ ID# ______________________ Group# ______________

Insurance address ____

For the following questions, circle yes or no:

Your answers are for our records only and are considered confidential. During your visits, you may be asked additional questions about your responses concerning your health.

1. Are you in good health? Y N My last physical examination was on: ______________________
2. Has there been any change to your general health within the past year? ______________________Y N
3. Are you now under the care of a physician? ____Y N
   If so, what is the condition being treated? ____
4. Name and address of your physician is:____
   ____
5. Have you had any serious illness, operation, or injury, or been hospitalized in the last 5 years? _________Y N
   If so, what was the illness or problem? ____
6. Are you taking any medications, including non-prescription medicine? ______________________Y N
   If so, what medicines are you taking? ____
7. Do you have or have you had any of the following diseases or problems:
   a. Any heart valve related problems (replacements, murmurs, rheumatic fever)? _____________Y N
   b. Cardiovascular disease (heart attack, angina, coronary vessel occlusion, high blood pressure, stroke)? ____Y N
      1. Do you have chest pain upon exertion? ____Y N
      2. Are you short of breath after mild exercise or when lying down? _____________________Y N
      3. Do your ankles swell? ____Y N
      4. Do you have inborn heart defects? ____Y N
      5. Do you have a pacemaker? ____Y N
      6. Are you taking blood thinners? ____Y N
   c. Allergies? ____Y N
   d. Sinus trouble? ____Y N
   e. Asthma or hay fever? ____Y N
   f. Fainting spells or seizures? ____Y N
   g. Persistent diarrhea or unusual weight loss? _______________________________________Y N
   h. Diabetes? ____Y N
   i. Hepatitis, jaundice, or liver disease? ____Y N
   j. AIDS or HIV infection? ____Y N
   k. Thyroid problems? ____Y N
   l. Respiratory problems, emphysema, bronchitis? ______________________________________Y N
   m. Arthritis or painful, swollen joints? ____Y N
   n. Stomach ulcer? ____Y N
   o. Kidney trouble? ____Y N
   p. Tuberculosis? ____Y N
   q. Persistent cough or bloody cough? ____Y N
   r. Persistent swollen glands in the neck? ____Y N
   s. Low blood pressure? ____Y N
   t. Sexually transmitted disease? ____Y N

David A. Dischler, D.D.S., P.C.

Patient Information and Health History

- u. Epilepsy or other neurological problems? ______________________________ Y N
- v. Mental health problems? ______________________________ Y N
- w. Cancer or tumors? ______________________________ Y N
- x. Problems with the immune system? ______________________________ Y N

8. Have you ever had an abnormal bleeding episode? ______________________________ Y N
   a. Have you ever required a blood transfusion? ______________________________ Y N
9. Do you have any blood disorder, such as anemia? ______________________________ Y N
10. Have you ever been treated for osteoporosis or are you taking Fosamax? ______________ Y N
11. Are you allergic or have you ever had a reaction to:
    a. Local anesthetic ______________________________ Y N
    b. Penicillin or other antibiotic ______________________________ Y N
    c. Sulfa drugs ______________________________ Y N
    d. Barbiturates, sedatives, or sleeping pills ______________________________ Y N
    e. Aspirin ______________________________ Y N
    f. Iodine ______________________________ Y N
    g. Codeine or other narcotics ______________________________ Y N
    h. Other ______________________________
12. Have you had any serious trouble with any previous dental treatment? ______________ Y N
    a. If so, explain ______________________________
13. Do you have any disease, condition, or problem, not listed above that you think I should know about? If so, explain ______________________________
14. Are you wearing contact lenses? ______________________________ Y N
15. Are you wearing removable dental appliances? ______________________________ Y N

Women:

16. Are you pregnant and/or nursing? ______________________________ Y N
17. Are you using birth control medications? ______________________________ Y N
    (antibiotics inactivate birth control medications)

Chief dental complaint: ______________________________

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold my dentist or any other member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

____

Signature of Patient

____

For completion by the dentist:

Comments on patient interview concerning medical history:

____

____

Significant findings from questionnaire or oral interview: ______________________________

Dental management considerations: ______________________________

Date ______________ Signature of Dentist ______________________________

Medical history updates:

Date	Comments	Signature