Halls Family Dentistry

Patient Name: _____ **Date:** _____
First *MI* *Last*

Preferred Name: _____ **Date of Birth:** _____

Social Security Number: _____ **Gender:** M F *(circle)*

Address: _____
Street

_____
City State Zip Code

Email: _____ **Phone:** _____

- ❑ ADD/ADHD
- ❑ AIDS
- ❑ Anemia
- ❑ Alcohol/Drug Abuse
- ❑ Arthritis
- ❑ Artificial Bones/Joints _____ *(what,when)*
- ❑ Artificial Heart Valve _____ *(when)*
- ❑ Asthma
- ❑ Blood Disease
- ❑ Cancer: *Type-* _____
- ❑ Cold Sores/Fever Blisters
- ❑ COPD
- ❑ Diabetes: *Type-* _____
- ❑ Dizziness / Fainting
- ❑ Epilepsy / Seizures
- ❑ Eating Disorder
- ❑ Excessive Bleeding
- ❑ Glaucoma
- ❑ Hay Fever
- ❑ Head Injury
- ❑ Headaches
- ❑ Heart Disease
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Pacemaker
- ❑ Heart Surgery
- ❑ Mitral Valve Prolapse
- ❑ Congenital Heart Defect
- ❑ High Blood Pressure
- ❑ HPV
- ❑ Low Blood Pressure
- ❑ Hepatitis: *Type-* _____
- ❑ Jaundice
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Mental Health Care
- ❑ Pregnancy (*currently)*
- ❑ Nursing (*currently)*
- ❑ Radiation/Chemotherapy
- ❑ Respiratory Problems
- ❑ Rheumatic Fever
- ❑ Sinus Problems
- ❑ Stomach Problems
- ❑ Tobacco
- ❑ Stroke
- ❑ Thyroid Disorders
  - ❑ Hyperthyroid
  - ❑ Hypothyroid
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Other: _____ _____ _____ _____
- ❑ Have you ever taken any osteoporosis medication? __ Yes __ No
- ❑ Are you required to take a premedication prior to dental appointment? __ Yes __ No

Please list ALL current medications: _____
_____
_____

Please list any allergies: _____
Have you ever had any complications following dental treatment? (*circle)* Yes or No
If yes, please specify: _____
Are you under the care of a physician? (*circle)* Yes or No
If yes, then please list their name: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes in my health, I will inform the doctor at the next appointment without fail.

Signature_____ Date: _____