Family Dentistry at Hawks Prairie - Truyen O'Leary, DDS

Health and Dental History

Patient Name: _____Preferred Name:_____

Age:_____ Birthdate:_____ Sex: M F

Physician's Name: _____ Physician's Phone:_____

Please check any of the following conditions that you have, or have had previously:

____Heart Attack	____Heart Murmur	____Pacemaker/Heart Stents
____Congenital Heart Disease	____Mitral Valve Prolapse	____Damaged Heart Valves
____High Blood Pressure	____Low Blood Pressure	____Artificial Joints
____Angina	____Blood Clots	____Stroke
____Artificial Heart Valves	____Dizziness	____Rheumatic Fever
____Asthma	____Emphysema	____Sinus Troubles
____Kidney Problems	____Cancer	____Epilepsy/Seizures
____Hepatitis	____Diabetes	____AIDS/HIV
____Thyroid Problems	____Tuberculosis	____Mental Health Disorder
____Trigeminal Neuralgia	____Major Surgeries	____Limited Jaw Opening
____Clenching/Grinding	____Jaw Pain	____Loose Teeth
____Bad Breath	____Sensitive/Painful Teeth	____Bleeding Gums
____Food Packs in Teeth	____Difficulty in Chewing	

List any other conditions you have that are not listed above:_____

Women: Are you pregnant at this time? Y / N Due Date:_____ Women: BCP Y / N

Medications you are currently taking: _____

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS?_____

Patient (Parent's) Signature:_____Date:_____