Family Dentistry At Hawks Prairie—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	_____Pacemaker/Heart Stents	_____Congenital heart disease
_____Damaged Heart Valves	_____Mitral Valve Prolapse	_____Angina
_____High Blood Pressure	_____Low Blood Pressure	_____Dizziness
_____Stroke	_____Blood Clots	_____Artificial Joints
_____Asthma	_____Emphysema	_____Sinus Troubles
_____Kidney Problems	_____Thyroid Problems	_____Cancer
_____Diabetes	_____Hepatitis	_____AIDS/HIV
_____Trigeminal Neuralgia	_____Tuberculosis	_____Mental Health Disorder
_____Major Surgeries	_____Epilepsy/Seizures	_____Limited Jaw Opening
_____TMJ/TMD	_____Clenching/Grinding	_____Jaw Pain
_____Migraines	_____Loose Teeth	_____Painful Teeth

Would you like information about using **Botox** for migraines, jaw pain, clenching and grinding?   Y / N

Women: Are you pregnant currently?   Y / N   Due Date: ____________   Women: BCP?   Y / N

Do you have any other conditions not listed above? ____

Medications you are currently taking: ____

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ARE YOU **ALLERGIC** TO ANY MEDICATIONS? ____

Patient (Parent's) Signature: ____Date: _____________