Health History Form

Personal Information

Patient Name:____ Date:______________
Last First Middle

Sex (circle): Male or Female Date of Birth: ______________

Occupation:________________________________ Date of last dental exam:___________________

If you are completing this form and you are not the patient named above, what is your relationship to this person?

____ ________________________________
Name Relationship

Medical Information

__Note:__ Dr. Anderson and Dr. Moreno encourage you to answer these questions honestly and with detail. Both doctors treat all patients respectfully, and there is no judgement or prejudice. Health conditions you have can affect the health in your mouth. __All__ information is confidential and is used only to help the doctors to propose the safest and most appropriate dental treatment plan for you.

Medical Doctor Name:__________________________ Doctor Phone#:___________________________

Have you had any operations? If yes, please explain:____
____

Are you taking any Herbal Supplements? If yes, please list:______________________________________

Have you taken bisphosphonate medications such as Fosamax, Boniva, Actonel, Atelvia, Reclast? Yes/No

Has your doctor told you to take antibiotics before dental work? Yes/No

Do you use drugs or similar substances for fun? If yes, please list:________________________________

Do you smoke/dip/chew tobacco products? If yes, please list type:________________ How many times a day or week?_____________________________________

Medications

Please List all of your medications __or__ attach a page separately:____
____
____

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Allergies

Please **circle and/or list** specifically if you have allergies to any of these items below:

Latex	Sulfa Drugs	Metal
Aspirin	Seasonal Allergies	Ibuprofen/Motrin
Codeine	Sedatives/Sleeping Pills	Antibiotics ___________________________

Please list any other allergy not listed:____

Health Conditions

Please circle if you **have** or **had** any of the following conditions. (If not applicable, leave blank.)

Abnormal Bleeding Experience	Fibromyalgia	Cancer:_____________________
AIDS or HIV	Infective Endocarditis	Radiation Therapy
Anemia	MRSA	Chemotherapy
Arthritis	Diabetes (Type 1 or Type 2)	Swollen Neck Glands
Asthma	Bulimia	Breathing Problems
Blood Transfusion Date:____________	Seizures	Migraines
Heart Disease/Attack	Acid Reflux	Sexually Transmitted Disease
Heart Valve Replacement/Pacemaker	Glaucoma	Lupus
Autism	Hemophilia	Thyroid
Congenital Heart Defect	Hepatitis (Type: A, B, C)	Frequent Bathroom Breaks
High Blood Pressure	Stroke	Ulcer
Brain/Nerve Disorders	High Cholesterol	Lupus
Kidney Problems	Osteoporosis	Attention Deficit Disorder

Mental Health Diagnosis: Depression, Bipolar Disorder, Schizophrenia, Anxiety Other:________________________
Do you have a condition not listed above? If yes, please list:____

I certify that I have read and understand this form. I will not hold Alamo Springs Dental doctors or staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. I will notify my dentist of any changes in my health.

Health History Form

____
Signature of Patient/Legal Guardian

____
Doctor Signature after Review

Updated MEDICAL HISTORY Addendum MARCH 2020

Alamo Springs Dental Medical History

Due to concerns about the spread of viruses like the Flu (Influenza Virus) and the Coronavirus (COVID-19), we have added a few questions that we are asking **all** patients to help keep our patients, team members and doctors informed and safe as possible. Please respond to the questions below.

1. Do you have acute respiratory illness **including frequent cough/sneezing, fever, and/or shortness of breath**?

   YES **NO**

2. Have you had a recent **trip to one of the states or countries that the CDC has listed as high risk for COVID-19 within the past 14 days**?

   YES **NO** **Unsure**

If you are **unsure**, where have you traveled in the past 14 days?____

____

3. Have you had close contact with someone who is under investigation for coronavirus infection?

   YES **NO**

Patient Name PRINTED: I, ___________________________________ have answered these questions to the best of my ability.

Patient Signature: ____ Date: _____________________________

Find more information at: WWW.CDC.GOV/covid19 www.dshs.texas.gov/coronavirus

***Thank you for your cooperation and patience at this time as we do our best to keep our patients and staff safe*.**