

Ponce de Leon Family Dentistry

4 St. Johns Medical Park Drive

St. Augustine, FL 32086

Phone: (904) 797-9009 Fax: (904) 797-9057

HEALTH HISTORY

HEALTH INFORMATION

PLEASE PRINT

Date _____

Patient's Name _____ Date of Birth _____

If completing this form for another person, what is your name and relationship to that person?

Is there anything you wish to discuss in private with the doctor? Yes _____ No _____

For the following questions, **circle Yes or No**. Your answers are for our records only and will be kept confidential.

- | | | | | | |
|---|-----|----|---|-----|----|
| 1. Are you in good health? | Yes | No | 29. TB, Tuberculosis (Self, Family, Household) | Yes | No |
| 2. Has there been any change in your general health within the past year? | Yes | No | 30. Persistent cough/ cough that produces blood | Yes | No |
| Have you ever had or do you now have? | | | 31. Arthritis or painful/swollen joints | Yes | No |
| 3. Pacemaker | Yes | No | 32. Artificial joint replacement | Yes | No |
| 4. Heart Murmur | Yes | No | 33. Stomach ulcer or hyperacidity | Yes | No |
| 5. Mitral valve prolapse | Yes | No | 34. Kidney trouble or dialysis | Yes | No |
| 6. Rheumatic heart disease | Yes | No | 35. Persistent swollen glands in neck | Yes | No |
| 7. Damaged heart valve | Yes | No | 36. Sexually transmitted disease | Yes | No |
| 8. Heart trouble | Yes | No | 37. Epilepsy or other neurological disease | Yes | No |
| 9. Heart attack | Yes | No | 38. Psychotherapy | Yes | No |
| 10. Angina | Yes | No | 39. Problems with mental health | Yes | No |
| 11. High Blood Pressure | Yes | No | 40. Cancer | Yes | No |
| 12. Arteriosclerosis (hardening of the arteries) | Yes | No | 41. Problems of the immune system | Yes | No |
| 13. Stroke | Yes | No | 42. Rheumatic fever or scarlet fever | Yes | No |
| 14. Chest pain upon exertion | Yes | No | 43. Abnormal bleeding | Yes | No |
| 15. Shortness of breath after mild exercise or when lying down? | Yes | No | 44. Blood transfusion | Yes | No |
| 16. Swollen ankles | Yes | No | 45. Blood disorders such as anemia | Yes | No |
| 17. Congenital heart defect | Yes | No | 46. Tumor or growth | Yes | No |
| 18. Prosthetic (artificial) heart valve | Yes | No | 47. Allergic or other reaction to | | |
| 19. Allergy | Yes | No | a. local anesthetics or dental anesthetics | Yes | No |
| 20. Sinus trouble | Yes | No | b. Penicillin or other antibiotics | Yes | No |
| 21. Asthma or hay fever | Yes | No | c. Sulfa drugs | Yes | No |
| 22. Fainting spells or seizures | Yes | No | d. Barbiturates, sedatives, or sleeping pills ... | Yes | No |
| 23. Persistent diarrhea or recent weight loss | Yes | No | e. Aspirin | Yes | No |
| 24. Diabetes | Yes | No | f. Codeine | Yes | No |
| 25. Hepatitis, jaundice or liver disease | Yes | No | g. Other | Yes | No |
| 26. AIDS or HIV infection | Yes | No | Women | | |
| 27. Thyroid problems | Yes | No | 48. Are you pregnant? | Yes | No |
| 28. Respiratory problems, emphysema, bronchitis, etc. | Yes | No | 49. Do you have any problems associated with your menstrual period? | Yes | No |
| | | | 50. Are you nursing? | Yes | No |

Please explain YES answers above and list serious illnesses, operations and hospitalizations within past five years:

Are you taking any medications (including non prescription)? _____

Tobacco use: Current Past Never used Type _____ Amount per day _____ Date tobacco use stopped _____

Alcohol use: Current Past Never used Describe usage:

Names of your primary health care practitioners (MD, DC, DO, etc.):

Name _____ Specialty _____ City _____

Name _____ Specialty _____ City _____

Are you now under the care of a doctor? Yes No If Yes, what is the condition being treated?

I certify that I have read and understood the above. I acknowledge that any questions I had about the inquiries above have been answered to my satisfaction. I will not hold my dentist, or any member of his staff, responsible for any errors that I may have made in the completion of this form.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN

Date