CONFIDENTIAL HEALTH HISTORY

Southpointe Dental
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Fargo, ND 58104
Phone (701) 280-1941

Patient Name: ____ Date of Birth: _____________________

Are you being treated by a physician now? If YES, explain____

Name of physician/Clinic: ______________________ Date of last medical examination ________________

DO YOU SMOKE OR USE TOBACCO PRODUCTS? YES NO

ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Select All That Apply)

- ❑ Aspirin Allergy
- ❑ Antibiotics
- ❑ Codeine Allergy
- ❑ Latex Allergy
- ❑ Penicillin Allergy
- ❑ Local Anesthetic
- ❑ Novocain
- ❑ Food:________________________________

Other Allergies: ____

MEDICAL CONDITIONS - (Select All That Apply)

- ❑ Arthritis
- ❑ Acid Reflux
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Artificial Heart Valve
- ❑ Blood Disorder
- ❑ Cancer / Tumor
- ❑ Chemotherapy or Radiation
- ❑ Chemical Dependency
- ❑ Cosmetic Surgery
- ❑ Diabetes
- ❑ Digestive Problems
- ❑ Damaged Heart Valve
- ❑ Eating Disorder
- ❑ Emphysema
- ❑ Headaches/Migraines
- ❑ High Blood Pressure
- ❑ Heart Attack / Disease
- ❑ Hepatitis / Liver Disorder
- ❑ HIV+ / AIDS
- ❑ Herpes
- ❑ Hay Fever
- ❑ Kidney Disease/Trouble
- ❑ Lung Disease
- ❑ Low Blood Pressure
- ❑ Osteoporosis
- ❑ Persistent Cough
- ❑ Pregnant or Nursing
- ❑ Psychiatric Care
- ❑ Pacemaker
- ❑ Respiratory Problems
- ❑ Skin Disease
- ❑ Stroke
- ❑ Sinus Trouble
- ❑ Sleep Apnea/CPAP
- ❑ STD
- ❑ Seizures / Epilepsy
- ❑ Tuberculosis (TB)
- ❑ Surgery: ______________________________________
- ❑ Other: ____

ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST *THREE* MONTHS? (Please circle)

Antibiotics   Aspirin   Coumadin   Blood Thinners   Birth Control:____________

Recreational Drugs   Bisphosphonates: Fosamax, Actonel, Boniva, Reclast, Didronel, Zometa, Skelid

MEDICATIONS AND PRESCRIPTIONS: Please list any supplements, prescriptions or recreational drugs:

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Is there any issue or condition that you would like to discuss with the dentist in private? YES NO

I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes in my health and/or medications. I authorize the dentist to contact my physician if needed regarding concerns of my medical information. If Dr Lichtsinn should determine that there may be a potential medically compromised situation, medical consultation may be needed prior to dental treatment. I will not hold my dentist or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.
In addition, I authorize Southpointe Dental to use anonymous photos of my teeth for publications, web pages and other educational materials produced and representing Southpointe Dental without compensation to me. I authorize contact from this office to confirm appointments, treatment and billing information via Phone, Email or Fax

Signature of Patient **(parent or guardian)** ______________________________________ **Date**____________________