Franziska K. Dutton DDS

Confidential Medical Health Information

(Please Print Legibly)

Patient Name:_____ Birthdate:_____

Physician Name_____ Phone: _____

Physician Address: _____

Please √ ☐ Yes or ☐ No below:

Yes	No		Date of event
☐	☐	Prosthetic heart valve	__/__/___
☐	☐	History of endocarditis	__/__/___
☐	☐	Congenital heart disease (excluding Mitral Valve Prolapse)	
☐	☐	Heart transplant	__/__/___
☐	☐	Heart bypass	__/__/___
☐	☐	Angioplasty/stent	__/__/___
☐	☐	Heart attack	__/__/___
☐	☐	Artificial joint	__/__/___
☐	☐	Surgeries (type and date): _____	

Yes	No	
☐	☐	Are you pregnant? ___ months
☐	☐	Physician care at present?
☐	☐	Tobacco use; Type_____ How long? _____ Amount per day: _____
☐	☐	"Osteoporosis" meds, e.g., Fosamax How long? _____
☐	☐	Hospitalized in past 2 years Describe: _____ _____

CIRCLE ANY OF THE FOLLOWING CONDITIONS THAT YOU HAVE OR HAD

A. AIDS	F. Epilepsy	K. Jaundice	P. Sexually Transmitted Disease
B. Arthritis	G. Glaucoma	L. Kidney Problems	Q. Stroke
C. Asthma	H. Hepatitis: Type____	M. Liver Problems/Cirrhosis	R. Substance Abuse / Alcoholism
D. Cancer*	I. High Blood Pressure	N. Low Blood Pressure	S. Tuberculosis
E. Diabetes: Type ____	J. HIV +	O. Respiratory Disease	T. Other Diseases*

* Comments:_____

ALLERGIES (Medicine, drug, other)

List: _____

MEDICATIONS (Including Herbal Supplements)

Medicine	Dose/Frequency	Medical Condition	Pharm (DDS to complete)

Attach separate list of medications if more than 8 taken

(Please turn over and complete the back side of this form.)

********** *Office use only* **********

VITAL SIGNS

Heart rate: _____BPM

Blood Pressure: _____mmHg

O_2 Saturation: _____%

ALTERATIONS TO PATIENT CARE

_____

_____

_____

PROPHY ANTIBIOTICS NEEDED? ☐ YES ☐ NO

If Yes, type:_____

MD consult prior to dental tx? ☐ **YES** ☐ **NO**

Who will prescribe? ☐ **MD** ☐ **DDS**

Franziska K. Dutton DDS

Dental Health Information

Previous Dentist: Name:_____ Date of last visit: _____
Address: _____ Phone Number: _____

How did you hear about our office? _____
Reason for dental visit? _____
Do you prefer to save your teeth? ☐ YES ☐ NO

Yes	No	**Have you had…**
☐	☐	Regular Preventive Dental Visits?
☐	☐	X-rays taken? Date of last X-rays: _____
☐	☐	Home Care Instructions?
☐	☐	Root Planing (e.g. "deep cleaning"?)
☐	☐	Fluoride Treatments?
☐	☐	Teeth Bleaching?
☐	☐	Local anesthetic?
☐	☐	Adverse reaction to anesthetic? Explain: _____

Yes	No	**Have a history of…**
☐	☐	Dental Phobia? Describe: _____
☐	☐	Dental Decay?
☐	☐	Jaw Joint pain? Describe: _____
☐	☐	Teeth grinding?
☐	☐	Jaw clenching?
☐	☐	Mouth breathing?
☐	☐	Dental injury?
☐	☐	Special dental problems? Describe: _____

Yes	No	**Have sensitivity to…**
☐	☐	Heat?
☐	☐	Cold?
☐	☐	Sweets?
☐	☐	Biting Pressure?
☐	☐	Dental Bleaching?
☐	☐	Other? Describe: _____

Emergency Contact: Name:_____ Address: _____
Phone: Home:_____ Work: _____ Mobile: _____

Patient Signature:_____ Date:_____

Dentist Signature:_____ Date:_____ Staff Initials: _____