NORTH POINT
DENTAL GROUP, LLC

PATIENT HEALTH HISTORY

Name: _____ Who is your medical doctor? _____

Have you taken any medications or drugs in the past two years? .....YES NO

Are you now taking any medications, drugs, or pills? .....YES NO

If yes, please list: _____

_____

Are you aware of being allergic to, or have you ever reacted adversely to any medication or substance?.....YES NO

If yes, please list: _____

Do you have any bleeding disorder, or are you taking any blood thinning medications? ..... YES NO

Indicate which of the following you have had or have at present. Circle "Yes" or "No" to each item.

Heart (Disease, Attack, Surgery).. YES NO	Kidney Problems..... YES NO	Special Diet..... YES NO
Shortness of breath..... YES NO	Ulcers..... YES NO	Unexplained Weight change.... YES NO
Congenital Heart Disease.....YES NO	Diabetes.....YES NO	Hepatitis (A, B or C, which)..... YES NO
Heart Murmer.....YES NO	Thyroid Problems..... YES NO	Immunocompromised..... YES NO
High Blood Pressure..... YES NO	Emphysema.....YES NO	Blood Transfusion..... YES NO
Arteriosclerosis..... YES NO	Chronic Cough..... YES NO	Hemophilia.....YES NO
Mitral Valve Prolapse.....YES NO	Tuberculosis/PPD Positive..... YES NO	Anemia..... YES NO
Artificial Heart Valve.....YES NO	Asthma.....YES NO	Liver Disease..... YES NO
Heart Pacemaker.....YES NO	Hay Fever..... YES NO	Epilepsy or Seizures..... YES NO
Rheumatic Fever..... YES NO	Latex Allergy..... YES NO	Fainting or Dizzy Spells.....YES NO
Arthritis.....YES NO	Sinus Problems..... YES NO	Nervousness..... YES NO
Drug Addiction, Alcoholism.....YES NO	Cancer or Tumor..... YES NO	Psychiatric Treatment.....YES NO
Current Tobacco Use..... YES NO	Radiation Therapy.....YES NO	Glaucoma..... YES NO
Artificial Joints (hip, knee, etc.)....YES NO	Chemotherapy..... YES NO	Stroke..... YES NO

Do you have or have you had any diseases, condition, or problem not listed?.....YES NO

If yes, please list: _____

Have you been hospitalized in the last two years?.....YES NO

Women: Are you..... Pregnant: ☐ YES ☐ NO Nursing: ☐ YES ☐ NO Taking birth control pills? ☐ YES ☐ NO

Do you clench or grind your teeth? ☐ Day ☐ Night ..... YES NO

Are your jaws or teeth tired when you awaken?.....YES NO

Do you have pain in your jaw joint?.....YES NO

Are you happy with the appearance of your teeth?..... YES NO

Do you wish your teeth were whiter?.....YES NO

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency. I will notify the dentist of any health or medication changes. I authorize x-rays, oral exams, study models, photographs, and any other diagnostic aids deemed appropriate to make a thorough dental diagnosis. I authorize treatment, medication, and therapy that may be indicated. I understand there is a very low risk of nerve damage in the mouth from the administration and use of local anesthetics.

_____

Signature of Patient or Guardian Date