



# Boales Dental Care

## Health History

Patient Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Birthday: \_\_\_\_/\_\_\_\_/\_\_\_\_ Male / Female Parent (if child): \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Physicians Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Please check any of the following conditions you have had or have at present.

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> AIDS/HIV               | <input type="checkbox"/> Anemia                   | <input type="checkbox"/> Arthritis, Rheumatism  |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Artificial Joints        | <input type="checkbox"/> Asthma                 |
| <input type="checkbox"/> Back Problems          | <input type="checkbox"/> Bleeding abnormally      | <input type="checkbox"/> Blood Disease          |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Chemical Dependency      | <input type="checkbox"/> Chemotherapy           |
| <input type="checkbox"/> Circulatory Problems   | <input type="checkbox"/> Congenital Heart Defects | <input type="checkbox"/> Cortisone Treatments   |
| <input type="checkbox"/> Cough, persistent      | <input type="checkbox"/> Diabetes Type _____      | <input type="checkbox"/> Emphysema              |
| <input type="checkbox"/> Epilepsy               | <input type="checkbox"/> Fainting or dizziness    | <input type="checkbox"/> Glaucoma               |
| <input type="checkbox"/> Headaches              | <input type="checkbox"/> Heart Murmur             | <input type="checkbox"/> Heart Problems         |
| <input type="checkbox"/> Hepatitis Type _____   | <input type="checkbox"/> Herpes                   | <input type="checkbox"/> High Blood Pressure    |
| <input type="checkbox"/> Jaundice               | <input type="checkbox"/> Jaw Pain                 | <input type="checkbox"/> Kidney Disease         |
| <input type="checkbox"/> Liver Disease          | <input type="checkbox"/> Low Blood Pressure       | <input type="checkbox"/> Mitral Valve Prolapse  |
| <input type="checkbox"/> Nervous Problems       | <input type="checkbox"/> Pacemaker                | <input type="checkbox"/> Psychiatric Care       |
| <input type="checkbox"/> Radiation Treatment    | <input type="checkbox"/> Respiratory              | <input type="checkbox"/> Rheumatic Fever        |
| <input type="checkbox"/> Scarlet Fever          | <input type="checkbox"/> Shortness of Breath      | <input type="checkbox"/> Sinus Trouble          |
| <input type="checkbox"/> Skin Rash              | <input type="checkbox"/> Stroke                   | <input type="checkbox"/> Swollen Feet or Ankles |
| <input type="checkbox"/> Swollen Glands         | <input type="checkbox"/> Thyroid Problems         | <input type="checkbox"/> Tonsillitis            |
| <input type="checkbox"/> Tuberculosis           | <input type="checkbox"/> Tumors                   | <input type="checkbox"/> Ulcer                  |
| <input type="checkbox"/> Venereal Disease       | <input type="checkbox"/> Contact lenses           | <input type="checkbox"/> Other _____            |

Y / N Pregnant Due Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Y / N Nursing Y / N Taking Birth Control Pills

Please check any of the following Allergies you have had or have at present.

Aspirin  Codeine  Iodine  Latex  Penicillin  Sulfa

Other: \_\_\_\_\_

Medications: \_\_\_\_\_

Former Dentist \_\_\_\_\_

Date of Last X-rays \_\_\_\_\_ Date of Last Dental Exam \_\_\_\_\_

Reason For Today's Visit \_\_\_\_\_

Patient ( Parent's) Signature: \_\_\_\_\_ Date: \_\_\_\_\_