PARKWOOD DENTAL

OSCAR HERNANDEZ, JR. D.M.D.

Updated Health History

Patient Name_____ Today's Date_____

Address_____ City/State/Zip Code_____

Cell Phone_____ E-Mail_____

Preferred Pharmacy Name: _____ Pharmacy Number: _____

Medical History:

Are you under medical treatment now? □ Yes □ No If yes, for what_____

Have you been hospitalized for any surgical operation or serious illness within the last 5 years? □ Yes □ No

If yes, please explain: _____

List <u>all</u> medications you are currently taking, including over the counter medications, vitamins, and natural or holistic remedies. Include dose and how often you take it: _____

_____

Have you ever needed to take pre-medication (antibiotics) before dental treatment ? □ Yes □ No

Please list all Allergies to Medicines:

Medication: _____ Reaction: _____

_____ _____

_____ _____

Please check any medical conditions you had or currently are experiencing (attach sheet if necessary):

	Yes	No		Yes	No		Yes	No
Anemia	□	□	Arthritis	□	□	Artificial Joints	□	□
Asthma	□	□	Blood Disease	□	□	Cancer	□	□
Chest Pains/Angina	□	□	Diabetes	□	□	Dizziness	□	□
Epilepsy	□	□	Emphysema	□	□	Fainting	□	□
Glaucoma	□	□	Heart Injury	□	□	Heart Disease	□	□
Heart Murmur	□	□	Hepatitis	□	□	HIV/AIDS/STD	□	□
High Blood Pressure/Low BP	□	□	Jaundice	□	□	Kidney Disease	□	□
Liver Disease	□	□	Mental Disorders	□	□	Nervous Disorders	□	□
Pacemaker	□	□	Radiation Therapy	□	□	Respiratory Problems	□	□
Rheumatic Fever	□	□	Sinus Problems	□	□	Stomach Problem	□	□
Stroke	□	□	Thyroid Problem	□	□	Tuberculosis	□	□
Tumors	□	□	Ulcers	□	□	Other	□	□

Are you taking any medication for bone density/biphosphonates? □ Yes □ No

Are you pregnant/nursing ? □ Yes □ No Maybe pregnant Are you on Birth Control? □ Yes □ No

When scheduling your appointment(s), the time is reserved exclusively for you. If you fail to notify us of your inability to keep your appointment, it prevents us from treating another patient in need of emergency care and/or treatment. **If you are unable to keep your appointment, please notify us 48 hours in advance to avoid a $50.00 fee. If we are unable to confirm your appointment it may be given to another patient in need of treatment that we are able to confirm.**

_____ _____ _____ _____

Patient signature Date Doctor Signature Date

rev092022