South Kitsap Family Dentistry

PATIENT INFORMATION

Patient Name: _____Date of Birth:_____

Address_____ Email_____

Home#_____ Work#_____ Cell# _____

Dental Insurance(s)_____

Preferred Pharmacy (Name and City)_____

HEALTH HISTORY

Medical Doctor's Name:_____ Physician's Ph#_____

Date of last physical? _____

PLEASE CHECK ALL THAT APPLIES

- ❑ AIDS/HIV
- ❑ Anemia
- ❑ Arthritis, Rheumatism
- ❑ Artificial Heart Valves
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Back Problems
- ❑ Bleeding abnormally
- ❑ Blood Disease
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Circulatory Problems
- ❑ Heart Lesions
- ❑ Cortisone Treatments
- ❑ Cough, persistent or bloody
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fainting or dizziness
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart Murmur
- ❑ Heart Problems
- ❑ Hepatitis ____
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Jaundice
- ❑ Jaw Pain
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Mitral Valve Prolapse
- ❑ Nervous Problems
- ❑ Pacemaker
- ❑ Psychiatric Care
- ❑ Radiation Treatment
- ❑ Respiratory Disease
- ❑ Rheumatic Fever
- ❑ Shortness of Breath
- ❑ Sinus Trouble
- ❑ Skin Rash
- ❑ Stroke
- ❑ Swelling of Feet or Ankles
- ❑ Swollen Neck Glands
- ❑ Thyroid Problems
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tumor or growth on head or neck
- ❑ Ulcer
- ❑ Venereal Disease
- ❑ Weight loss or gain, unexplained
- ❑ Other _____ _____ _____ _____

Women: Are you now or do you plan to become pregnant? **Yes/No** Due Date:_____

Are you nursing? **Yes/No** Taking birth control pills? **Yes/No**

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis

_____

_____

_____

Are you taking aspirin or blood thinners?

_____

ALLERGIES

- ☐ Aspirin
- ☐ Barbiturates
- ☐ Codeine
- ☐ Local Anesthetic
- ☐ Latex
- ☐ Iodine
- ☐ Penicillin
- ☐ Sulfa

Metals, if so, type: _____

Other _____

Any other concerns :

_____

_____

Signature _____ Date _____