diamond dental
SLEEP SOLUTIONS

Health Information

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Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex
☐ Local Anaesthetic ☐ Other (if yes please explain)_____

Have you ever had any of the following? Please check if applies:

Y N		Y N		Y N	
☐☐	AIDS or HIV	☐☐	Genital Herpes	☐☐	Psychiatric Care
☐☐	Anemia	☐☐	Glaucoma	☐☐	Psychiatric Care
☐☐	Arthritis	☐☐	Hay Fever	☐☐	Radiation Treatment
☐☐	Artificial Heart valve	☐☐	Heart Attack/Failure	☐☐	Respiratory Problems
☐☐	Artificial Joints	☐☐	Heart Disease	☐☐	Rheumatic Fever
☐☐	Asthma	☐☐	Heart Murmur MVP	☐☐	Sinus Problems
☐☐	Blood Disease	☐☐	Heart PACE MAKER	☐☐	Stomach Problems
☐☐	Cancer	☐☐	Hepatitis A, B or C	☐☐	Stroke
☐☐	Chemotherapy	☐☐	High Blood Pressure	☐☐	Tuberculosis
☐☐	Diabetes	☐☐	Leukemia	☐☐	Tumors
☐☐	Drug Addiction	☐☐	Liver Disease	☐☐	Ulcers
☐☐	Epilepsy or seizures	☐☐	Kidney Disease	☐☐	Venereal Disease
☐☐	Excessive Bleeding	☐☐	Parathyroid disease	☐☐	OTHER:_____
☐☐	Fainting or Dizziness				

Have you ever had a serious head or neck injury? ( ) YES ( ) NO If yes please explain_____

Have you ever been told you need to pre-medicate with antibiotics prior to dental work? ( ) NO
( ) YES _____

Do you or have you taken Fosamax? ( ) YES ( ) NO _____

Are you on a special diet? ( ) YES ( ) NO _____

Do you use, or have you used, tobacco? ( ) YES ( ) NO _____

Do you use controlled substances? ( ) YES ( ) NO _____

☐ Please List ANY MEDICATIONS you are taking:_____

WOMEN: Are you: ☐ Pregnant? Due date_____ ☐ Taking Oral Contraceptives? ☐ Nursing?

In Case of **EMERGENCY** give **NAME** and **PHONE NUMBER** of someone **NOT LIVING WITH YOU**.

_____

Are you now under the care of a physician or have you ever had a serious illness not listed above?

( ) YES ( ) NO If yes please explain_____

Name of Physician: _____ Phone:_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment.

Signature of Patient (or parent or guardian) _____

Relationship to Patient:_____ Date:_____