PULIDO
DENTAL CARE
Hernando Pulido DDS - PA

HEALTH HISTORY

TODAY'S DATE: _____

PATIENT'S NAME: _____ SS# _____ DATE OF BIRTH: _____

MOBILE PHONE: _____ OTHER PHONE: _____

EMAIL: _____

ADDRESS: _____ CITY: _____STATE: _____ ZIP CODE: _____

EMERGENCY CONTACT'S NAME: _____ RELATIONSHIP:_____ PHONE:_____

WHAT IS THE REASON OF YOUR VISIT? _____

DENTAL INFORMATION

For-the following questions, please write YES or NO in the space.

1. Have you ever had a serious injury to your head or mouth? _____
2. Do your gums bleed when you brush or floss? _____
3. Are your teeth sensitive to cold, hot sweets or pressure? _____
4. Does food or floss catch between your teeth? _____
5. Is your mouth dry? _____
6. Have you had any problems associated with previous dental treatment? " _____
7. Do you have earaches or neck pains? _____
8. Do you have sores or ulcers in your mouth?_____
9. Do you have any clicking, popping or discomfort in the jaw? _____
10. Do you clench or grind your teeth? _____
11. Do you participate in active recreational activities? _____

Date of your last dental exam: _____

What was done at that time? _____

Date of last dental x-rays: _____

INSTRUCTIONS TO THE PATIENT: Answer the following questions as completely and accurately as possible. All information is confidential. Please circle "yes" or "no" to all questions, and write in your answers as appropriate.

1. The name and address of my physician_____

2. Has a physician treated you in the past six months? _____

If yes, for what condition?_____

3. Have you been hospitalized or have a serious illness (including MRSA infection) within the last five years? _____

If yes, please specify: _____

4. Are you allergic or had any adverse reaction to any medicines, drugs, local anesthetics, LATEX or other substances? _

If yes, please specify: _____

5. Do you now or have you ever smoked cigarettes or used tobacco products? _____

6. Have you had surgery or x-ray treatment for a tumor, growth or other condition of your head or neck? _____

If yes, please list: _____

WOMEN ONLY: Are you pregnant? _____ Number of weeks: _____ Are you currently nursing? _____

Are you taking Birth control pills or hormonal replacement? _____

7. Do you have or have you had any of the following diseases/problems? Please Write a Check ☑

	A. Abnormal bleeding, bruise or history of transfusion. Taking aspirin or blood thinner.
	B. Lung/Respiratory condition (asthma, bronchitis, emphysema
	C. Diabetes
	D. Emotional/Mental health disorder (anxiety, depression, bipolar disorder
	E. Epilepsy/Seizures/Convulsions
	F. Liver disease (Hepatitis/Jaundice/Cirrhosis).
	G. High blood pressure
	H. HN positive/AIDS
	I. Hives, itching or skin rash
	J. Kidney/Renal disease
	K. Sexually Transmitted Diseases
	L. Stomach ulcers
	M. Thyroid disease
	N. Tuberculosis
	O. Artificial/Prosthetic joint replacement (knee or hip)
	P. Angina/Chest pain, Shortness of breath Date: _____
	Q. Artificial/Prosthetic heart valves
	R. Valve damage following heart transplant
	S. Congenital heart disease
	T. Infective endocarditis (heart infection)
	U. Heart attack Date: _____
	V. Heart surgery Date: _____
	W. Stroke Date: _____
	X. Congestive heart failure
	Y. Coronary artery or other heart disease .
	Z. Arteriosclerosis/Coronary occlusion .
	AA. Pacemaker .
	DB. Implanted cardio-defibrillator .
	Cc. Immune suppression or deficiency .
	DD. Cancer/ChemolRadiation therapy .
	EE. Drug abuse (cocaine methamphetamines, heroin, crack) or drug rehabilitation
	FF. Alcohol abuse (alcoholrehabilitation) .

If you answered YES to any of the previous diseases, please explain in the following space

_____

_____

8. Do you have any other diseases, conditions, or problems not listed above? _____

If yes, please explain: _____

10. Are you taking or have you ever taken any medications, (examples below), either orally or by injection, for osteoporosis, osteopenia or bone loss due to aging OR lung cancer, breast cancer, prostate cancer, colorectal cancer, wet macular degeneration, Paget's Disease, or multiple myeloma? _____

Examples: Fosamax® (aiendronate); Boniva® (ibandronate); Actonel® (risedronate); Reclast® yearly injection (zoledronic acid); Aredia® (pamidronate); Zometa® (zoledronic acid); Bonefos® (clodronate); Avastin® (bevacizumab); Erbitux® (cetuximab); Herceptin® (trastuzumab)?

If yes, please check the appropriate medication below: _____

11. Please list any premedication. Medications, pills or drugs with dosage which you are taking both prescription and nonprescription

MEDICATION	DOSAGE	REASON PRESCRIBED
1.		
2.		
3.		
4.		

I certify that I have read and understand the above. I acknowledge that I have answered these questions accurately and completely. I will not hold my dentist responsible for any action taken or not taken because of errors or omitions I may have made when completing this form.

PATIENT SIGNATURE/GUARDIAN: _____ DATE SIGNED: _____