STEVENSHIMAMOTO, DMD

PATIENT HEALTH FORM

Name:_____ Sex: ☐ M ☐ F Date of Birth: _____

DO YOU HAVE ANY ALLERGIES OR SENSITIVIES? ☐ Yes ☐ No
If yes, please list: _____

Medicines you are taking: List medicines, birth control pills, herbal supplements or vitamins you take with or without a prescription.

_____ _____ _____

_____ _____ _____

_____ _____ _____

Are you under the care of a physician? ☐ Yes ☐ No If yes, for what condition? _____
If patient is a child, what is his/her weight? _____ lbs.
Are you pregnant or do you suspect you are pregnant? ☐ Yes ☐ No

Do you have one of these medical conditions that may require antibiotic prophylaxis before dental treatment?

- ☐ Joint Replacement
- ☐ Artificial Heart Valves
- ☐ Congenital Heart Conditions
- ☐ Cardiac Transplant
- ☐ History of Infective Bacterial Endocarditis
- ☐ Disease, Drug, or Radiation/Chemo induced immunosuppression
- ☐ Physician Advised Pre-Medication before dental treatment

Have you ever had any of the following?

- ☐ AIDS/HIV
- ☐ Arthritis
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Bleed heavily
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chronic Swollen Gums
- ☐ Circulatory Problems
- ☐ Diabetes
- ☐ Epilepsy
- ☐ General Allergies
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Hemophilia
- ☐ Hepatitis A, B or C
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Psychiatric Care
- ☐ Radiation Treatment

☐ Respiratory Disease

☐ Rheumatic Fever
☐ Sinus Problems
☐ Stroke
☐ Swollen Neck Glands
☐ Thyroid Disease
☐ Tuberculosis

☐ Ulcer

Is there anything else we should know about your medical history? _____
_____

How often do you brush your teeth? _____ How often do you floss? _____
When was the last time you went to a dentist and why? _____
Do you smoke? ☐ Yes ☐ No If yes, how many packs a day? _____ Do you use smokeless tobacco? ☐ Yes ☐ No
Do (or did) either of your parents wear dentures? ☐ Yes ☐ No Do you grind your teeth at night? ☐ Yes ☐ No
Have you ever felt dizzy after dental treatment? ☐ Yes ☐ No
Have you ever had any injuries to your face, teeth, or jaws? ☐ Yes ☐ No

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE

_____ _____
Patient, Parent or Guardian Signature Date