

Portia J. Bell D.D.S.

Patient Health History

Today's Date ___/___/___

Name (Last) _____ (First) _____ (M.I.) _____

Date of Birth _____

Have you had dental x-rays within the last 12 months? _____ If so, please bring copies of the x-rays to your appointment. If you choose not to obtain those x-rays, we will need to take a new series of x-rays which consist of a panoramic and bitewing x-rays.

What is the reason for your visit today? (Please check all that apply)

Evaluation/Cleaning _____
 Toothache/Consultation _____
 Broken Tooth Consultation _____
 Gum Problem _____
 Cosmetic Consultation/Evaluation _____

Have you had hip/knee replacement surgery or any heart surgery in the last two years? _____
 If you answered yes, please call our office at 471-1161 so that we may determine whether you may need an antibiotic prior to your appointment.

Are you allergic to any of the following?

- | Yes | No | Yes | No |
|--------------------------|--------------------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Penicillin | <input type="checkbox"/> | <input type="checkbox"/> Do you wear dentures or partials? |
| <input type="checkbox"/> | <input type="checkbox"/> Novocaine | <input type="checkbox"/> | <input type="checkbox"/> Do you wear contact lenses? |
| <input type="checkbox"/> | <input type="checkbox"/> Codeine | <input type="checkbox"/> | <input type="checkbox"/> Women, are you pregnant? Due Date: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> Aspirin | <input type="checkbox"/> | <input type="checkbox"/> Do you have active tuberculosis? |
| <input type="checkbox"/> | <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> | <input type="checkbox"/> Do you snore? |
| <input type="checkbox"/> | <input type="checkbox"/> Latex | <input type="checkbox"/> | <input type="checkbox"/> Have you seen a chiropractor? |
| <input type="checkbox"/> | <input type="checkbox"/> Amoxicillin | <input type="checkbox"/> | <input type="checkbox"/> Have you seen a neurologist? |
| <input type="checkbox"/> | <input type="checkbox"/> Other | | |

Do you have or have you ever had any of the following?

- | Yes | No | Yes | No |
|--------------------------|--|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> Heart problems | <input type="checkbox"/> | <input type="checkbox"/> Hepatitis A, B, or C |
| <input type="checkbox"/> | <input type="checkbox"/> Any Surgery | <input type="checkbox"/> | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> | <input type="checkbox"/> Stroke | <input type="checkbox"/> | <input type="checkbox"/> Bleeding problems |
| <input type="checkbox"/> | <input type="checkbox"/> Arthritis | <input type="checkbox"/> | <input type="checkbox"/> Heart murmur |
| <input type="checkbox"/> | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> Been in orthodontic treatment (braces) |
| <input type="checkbox"/> | <input type="checkbox"/> Sinus problems/allergies | <input type="checkbox"/> | <input type="checkbox"/> Clicking/Popping of Jaw |
| <input type="checkbox"/> | <input type="checkbox"/> Pain in joint/ear/side of face | | |
| <input type="checkbox"/> | <input type="checkbox"/> Difficulty opening or closing mouth | | |
| <input type="checkbox"/> | <input type="checkbox"/> Eye Surgery | | |