

## Dental & Health History

### Dr. Parisa Sepehri

Your overall health as well as any medications, which you take, could have an important interrelationship with the dental care you receive. Please answer each of the following questions completely.

Name \_\_\_\_\_ Sex \_\_\_\_\_ Birth date \_\_\_\_\_

Primary Care Doctor \_\_\_\_\_ Dr. Phone # \_\_\_\_\_  
First Name Last Name

Dr's Address: \_\_\_\_\_ City \_\_\_\_\_  
 \_\_\_\_\_ Zip \_\_\_\_\_

Previous hospitalizations/surgery/serious illnesses? \_\_\_\_\_  
 \_\_\_\_\_

Have you ever taken the medication Fosamax? Y / N

Are you currently taking any medication? Please list medication and purpose.

Medication	Purpose	Medication	Purpose
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

Do you have a history of allergies/sensitivities/adverse reactions to any drugs or medications? Y / N  
 If yes please describe.

\_\_\_\_\_  
 \_\_\_\_\_

Do you have allergies to latex or other substances?

\_\_\_\_\_

**DO YOU HAVE OR HAVE YOU HAD IN THE PAST:**

YES	NO		YES	NO	
___	___	Asthma	___	___	Handicaps/disabilities
___	___	Cancer	___	___	Tuberculosis
___	___	Hepatitis	___	___	Diabetes
___	___	HIV/AIDS	___	___	Kidney Disease
___	___	Abnormal Bleeding	___	___	Liver Disease
___	___	Blood Disease	___	___	Arthritis
___	___	Anemia	___	___	Epilepsy/Seizures
___	___	High Blood Pressure	___	___	Fainting/Dizziness
___	___	Stroke	___	___	Heart Murmur
___	___	Rheumatic Fever	___	___	Congenital Heart Defect
___	___	Ear Problems	___	___	Congestive Heart Failure
___	___	Headaches	___	___	Other: _____
___	___	Are you/or are you trying to become pregnant?	___	___	Radiation Therapy
___	___	Do you take birth control medication?	___	___	Allergies
___	___	Recreational or street drugs	___	___	Psychiatric Treatment

\_\_\_ Do you have a family history of diseases? If so please explain: \_\_\_\_\_  
 \_\_\_\_\_

Previous dentist \_\_\_\_\_ date of last visit \_\_\_\_\_

How often do you brush? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

Do you have any dental concerns or problems? \_\_\_\_\_

**AUTHORIZATION & RELEASE**

To the best of my knowledge the questions on this form have been accurately answered. I authorize the Dentist to release any information of my dental treatment and diagnosis to my insurance company. I also authorize and request my insurance company to pay directly to the Dentist benefits otherwise payable to me.

Signature of patient or parent if minor \_\_\_\_\_

Date \_\_\_\_\_