diamond dental
SLEEP SOLUTIONS

Health Information

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

Y N		Y N		Y N	
□□	AIDS or HIV	□□	Fainting or Dizziness	□□	Parathyroid disease
□□	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	□□	OTHER:_____
□□	Excessive Bleeding				

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 a head or neck injury? ( ) YES ( ) NO If yes please explain_____

Do you need to pre-medicate with antibiotics prior to dental work? ( ) YES ( ) NO If yes please explain

_____

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

In Case of **EMERGENCY** give contact **NAME** and **CELLPHONE NUMBER:**

_____

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 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:_____