

Kerry Kelly D.D.S.

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Health History - Dr. Kerry Kelly. DDS

Please fill in the following information. Your answers are for our records only and will be kept strictly confidential subject to applicable laws. Please note that you will be asked some questions concerning your health. This information is vital to allow us to provide you the best care possible.

General Information

First name - Patient Middle name Last name - Patient Nickname/Preferred name

Patient birth date Gender Marital status

Contact Information

Home # Mobile # Work #

Email address Preferred contact method Best time to call

Patient mailing address Patient billing address

Emergency Information

Emergency contact Emergency #

Family doctor Family doctor #

Other Information

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Has the main contact for the family, (usually a parent or guardian) changed since your last visit?

Has the main person responsible for payments for the family, (usually a parent or guardian) changed since your last visit?

Dental Information

- | | |
|---|--|
| <input type="checkbox"/> Do your gums bleed when you brush or floss? | <input type="checkbox"/> Are you currently experiencing dental pain or discomfort? |
| <input type="checkbox"/> Are your teeth sensitive to cold, hot, sweets, or pressure? | <input type="checkbox"/> Do you have earaches or neck pains? |
| <input type="checkbox"/> Does food or floss catch between your teeth? | <input type="checkbox"/> Do you have any clicking, popping or discomfort in your jaw? |
| <input type="checkbox"/> Have you had any periodontal (gum) treatment? | <input type="checkbox"/> Do you grind your teeth? |
| <input type="checkbox"/> Have you ever had orthodontic (braces) treatment? | <input type="checkbox"/> Do you have any sores or ulcers in your mouth? |
| <input type="checkbox"/> Have you had any problems associated with previous dental treatment? | <input type="checkbox"/> Do you wear partial dentures? |
| <input type="checkbox"/> Is your home water supply fluoridated? | <input type="checkbox"/> Do you wear full dentures? |
| <input type="checkbox"/> Do you drink bottled or filtered water? | <input type="checkbox"/> Have you ever had a serious injury to your head, neck or mouth? |

Medical Information

Allergies

- | | | | |
|---|---|---|-----------------------------------|
| <input type="checkbox"/> Acetaminophen/Tylenol® | <input type="checkbox"/> Acrylic | <input type="checkbox"/> Animals | <input type="checkbox"/> Aspirin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Demerol | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Fluoride |
| <input type="checkbox"/> Food | <input type="checkbox"/> Hay fever/seasonal | <input type="checkbox"/> Ibuprofen/Motrin®/Advil® | <input type="checkbox"/> Iodine |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Local anesthetic | <input type="checkbox"/> Metals | <input type="checkbox"/> Morphine |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Tetracycline | |
| <input type="checkbox"/> Other | | | |

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Reactions

Conditions

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Abnormal/excessive bleeding | <input type="checkbox"/> AIDS or HIV infection | <input type="checkbox"/> Alzheimer's/dementia | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Autoimmune disease | <input type="checkbox"/> Back problems | <input type="checkbox"/> Blood disease |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Breathing problems/
respiratory disease | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Cancer/chemotherapy/
radiation treatment |
| <input type="checkbox"/> Cardiovascular disease | <input type="checkbox"/> Chest pain upon exertion | <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Congestive heart failure |
| <input type="checkbox"/> Damaged heart valves | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Fainting spells or seizures | <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Gastrointestinal disease |
| <input type="checkbox"/> G.E. Reflux/persistent
heartburn | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Gout | <input type="checkbox"/> Hearing difficulties |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Heart rhythm disorder | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Hepatitis, jaundice or liver
disease | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> Low pain tolerance | <input type="checkbox"/> Malnutrition | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Neurological disorders |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Osteoporosis/Paget's disease | <input type="checkbox"/> Other congenital heart defects | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Persistent swollen glands in
neck | <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Recurrent infections | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Rheumatic heart disease | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Severe headaches/migraines | <input type="checkbox"/> Severe or rapid weight loss |
| <input type="checkbox"/> Sexually transmitted infection
(STI) | <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Stroke | <input type="checkbox"/> Systemic lupus erythematosus |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> TMJ Disorder | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tumors or growths |
| <input type="checkbox"/> Ulcers | | | |
| <input type="checkbox"/> Other | | | |

Details

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Please indicate if you have or any of the following diseases or problems.

Preferred pharmacy

-

Pharmacy #

-

Date of last physical exam

-

Do you have severe issues with coughing?

Have you ever reacted adversely to any medications or injections?

Do you drink alcoholic beverages?

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?

Has there been any change to your general health within the past year?

Do you use tobacco (smoking, snuff, chew, bidis)?

Have you had a serious illness, operation or been hospitalized in the past 5 years?

Are you wearing a nicotine patch?

Are you taking any prescription or over-the-counter medicines?

Do you have sleep apnea?

Are you pregnant?

Are you taking birth control or hormone replacement?

Are you nursing?

Please list any surgical procedures you have undergone and when they occurred.

Have you ever taken FosaMax®, Boniva®, Actonel® or other medications containing bisphosphonates?

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

Physician's phone number

-

Please read the above, and understand that the information provided in this form is accurate. A truthful health history will help ensure the best possible dental treatment. The information provided here will be used by the doctor and patient to inform any further discussion of the patient's health prior to or during an appointment. By signing below you also acknowledge that you will not hold the dentist, the dental practice or any other member of the practice staff responsible for any action or lack of action because of errors or omissions that may have been made during the completion of this form.

Signature

I agree that the information provided in this form is correct to the best of my knowledge.