HANSEN & ASSOCIATES

6659 KIMBALL DRIVE NW, SUITE D401, GIG HARBOR, WA 98335

NAME: _____ M / F AGE: _____ BIRTH DATE: _____ DATE: _____

MEDICAL HISTORY:

Do you or have you had any of the following?

Asthma……..Yes / No
Chronic Bronchitis…….Yes / No
Emphysema……Yes / No
Tuberculosis…… Yes / No
Tobacco Use……..…Yes / No
Excessive Coughing……Yes / No
Hay Fever……Yes / No
Sinus Problems…..……Yes / No

Blood Problems……..Yes / No
Blood Transfusion……..Yes / No
Prolonged Bleeding……Yes / No
Sickle Cell Disease……Yes / No
High Blood Pressure……...Yes / No
High Cholesterol…….Yes / No

Prolapse, Heart Valve……Yes / No
Angina Pectoris/ Chest Pain……...Yes / No
Congenital Heart Disease……Yes / No
Valvular Heart Disease……...Yes / No
Heart Arrhythmias……..Yes / No

Shortness of Breath……Yes / No
Chronic Low Grade Fever…….Yes / No
Rheumatic Fever……Yes / No
Scarlet Fever……..Yes / No
Chronic Pain……..Yes / No
Glaucoma ……..Yes / No

Osteoporosis……..Yes / No
Arthritis……Yes / No
Rheumatism……..Yes / No
Immune Disease ……..Yes / No
Artificial Joint/Device……..Yes / No
Bisphosphonate therapy ……..Yes / No
Kidney Dialysis……Yes / No
Kidney Problems……..Yes / No
Diabetes……Yes / No
Thyroid Problems……Yes / No

Herpes……..Yes / No
Venereal Disease……Yes / No

HIV positive……..…Yes / No
Do you have or have you
been exposed to AIDS?…….Yes / No
Hepatitis…….Yes / No

Depression……..Yes / No
Unusual Weight Loss…….Yes / No
Alcohol Abuse or Treatment……..Yes / No
Drug Abuse or Treatment……...Yes / No
Psychiatric Treatment…….Yes / No
Fainting or Dizzy Spells…….Yes / No
Migraines or Headaches…….Yes / No
Neurological Problems……...Yes / No
Epilepsy……..Yes / No

Cancer……Yes / No
Leukemia……Yes / No
Chemotherapy……Yes / No
Radiation/Cobalt Treatment……Yes / No
Tumor (Benign/Malignant)……Yes / No
Women (are you pregnant)…….Yes / No
Women (Mastectomy)……Yes / No

Have you been hospitalized within the past 5 years?

_____
_____

Any surgeries within the past 5 years?

_____
_____

Date of last physical exam: _____

Please list your current doctors and specialists, including location and phone numbers:

Dr._____
_____
Dr._____
_____
Dr._____
_____

ALLERGIES OR ADVERSE RESPONSES:

Antibiotics……..….Yes / No
Penicillin……Yes / No
Narcotics……Yes / No
Codeine……..Yes / No
Aspirin……Yes / No
Local Anesthetic…….Yes / No
Novacaine……..Yes / No
Latex Products……Yes / No
Iodine Products……..Yes / No
Sulfa……Yes / No
Other (please specify):

_____
_____

MEDICATIONS:

_____
_____
_____
_____
_____
_____

ADDITIONAL INFORMATION:

_____
_____
_____

I hereby certify that I have read and understand each question and have answered to the best of my ability. I understand that the information I have provided regarding myself or the patient listed above is essential to determine any provisions needed prior to receiving dental treatment. I am assuming full responsibility for notifying this office of any health changes that may occur or alter the above response.

Signature: _____
(Parent of guardian if patient is a minor or under the age of 18)

FOR OFFICE USE:

Vitals: BP: _____/_____ Pulse: _____ Date: _____ HHx Reviewed (initials): _____
Vitals: BP: _____/_____ Pulse: _____ Date: _____ HHx Reviewed/Updated (initials): _____
Vitals: BP: _____/_____ Pulse: _____ Date: _____ HHx Reviewed/Updated (initials): _____
Vitals: BP: _____/_____ Pulse: _____ Date: _____ HHx Reviewed/Updated (initials): _____
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Vitals: BP: _____/_____ Pulse: _____ Date: _____ HHx Reviewed/Updated (initials): _____

SEDATION: Nitrous Oxide: Y / N Oral: Y / N Type: _____ **PRE-MED**: Antibiotic: _____
Procedures: H R H R