Krystal Teague Dental Health History

Patient Name: _____

Are you currently being treated by a physician regularly for a serious health problem?

Yes□ No□

If yes, please explain and give physician's contact information: _____

_____

Please list all medications you are currently taking (prescribed or over the counter):

_____

_____

_____

Do you have any known allergies to latex, medications, or milk protein (please list):

_____

Have you ever been treated for: (circle all that apply)

Blood pressure	Heart Disease	Stroke	Artificial Joint
Rheumatic Fever	Heart Murmur	Heart Valve	Pacemaker
Hepatitis	Diabetes	Depression	Tuberculosis
Immune Disease	Asthma	Bleeding/Clotting	Dry Mouth

Has a physician told you to take antibiotics before a dental cleaning? _____ If yes, why?

_____

Do you use tobacco? _____ If yes, how much per day? _____

Do you consume alcohol? _____ If yes, how much per day/week? _____

Do you currently use recreation or street drugs? □Yes □No

I have read and completed the above answers to the best of my knowledge. I understand Krystal Teague Dental is not responsible for any missing information I did not provide above. I take full responsibility for any medications prescribed to me from Krystal Teague Dental.

Patient Signature: _____ Date: _____

Staff Initials _____