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Mary Anne Checchio DDS

PATIENT HEALTH HISTORY FORM

Name	Nickname		Date
Address	City	State	Zip Code
Home Phone	Mobile Phone		
Email Address			
Date of Birth SSN	Gender (M/F)	Height	Weight

For the following questions, circle YES or NO, whichever applies. Your answers are for our records only and will be kept confidential.

1.	**YES** **NO**	Has there been any change in your health in the past year? Please explain:
2.	/ /	When was your last Physical Exam? Month/Day/Year
3.		Name of Primary Care Physician (PCP): Phone #: Please list any conditions being treated for:
4.	**YES** **NO**	Do you see a cardiologist? Provide name/phone # When was the last time examined?
5.	**YES** **NO**	Have you had any serious illness, operation, or hospitalizations? Please list all:
6.	**YES** **NO**	Do you or any other family members have a history of problems with anesthesia? Please list:

PATIENT HEALTH HISTORY (continued)

7.	**YES**	**NO**	Have you had an artificial joint replacement (knee, hip, shoulder) or pins, plates, screws or rods? Please list:
8.	**YES**	**NO**	Do you have osteoporosis? Are you taking or have you taken bisphosphonates for osteoporosis or chemotherapy for multiple myeloma or other cancers? (Fosamax, Actonel, Boniva, Xgeva, Reclast, Aredia, Zometa)? Please circle or list:
9.	**YES**	**NO**	Are you taking any medications? Please list:
10.			Please list your Pharmacy name/address/phone number
11.			Do you have or have you had any of the following diseases or problems:
	YES	**NO**	Damaged heart valves, artificial valves, heart murmur?
	YES	**NO**	Heart trouble, heart attack, angina, arteriosclerosis or any other heart condition?
	YES	**NO**	• Chest pain on exertion?
	YES	**NO**	• Shortness of breath climbing two flights of stairs?
	YES	**NO**	• Do your ankles swell?
	YES	**NO**	Have you been diagnosed with Alzheimer's disease or dementia? Do you have a power of attorney for medical decisions? Please bring it with you.
	YES	**NO**	Diabetes?
	YES	**NO**	Hepatitis, jaundice, or liver disease?
	YES	**NO**	HIV/AIDs?
	YES	**NO**	Kidney disease?
	YES	**NO**	Tuberculosis?
	YES	**NO**	Persistent cough or cough that produces blood?
	YES	**NO**	High or Low Blood Pressure? Please Circle.
	YES	**NO**	Epilepsy or neurological disorder like Stroke?
	YES	**NO**	Cancer? Please List type:
	YES	**NO**	Sinus trouble? Asthma, hay fever or seasonal allergies?
	YES	**NO**	Respiratory problems, emphysema, bronchitis etc?
	YES	**NO**	Sleep apnea?
	YES	**NO**	Fainting spells?
	YES	**NO**	Thyroid problems?
	YES	**NO**	Arthritis, painful or swollen joints, including jaw joint (TMJ)?
	YES	**NO**	Stomach ulcer or hyperacidity?
	YES	**NO**	Persistent swollen neck glands?
12.	**YES**	**NO**	Have you had any abnormal bleeding?
	YES	**NO**	Have you ever required a blood transfusion?
13.	**YES**	**NO**	Do you have any blood disorder such as anemia?
14.	**YES**	**NO**	Have you ever had treatment for a tumor or growth?

PATIENT HEALTH HISTORY (continued)

15.	**YES**	**NO**	Have you had radiation therapy to the head, neck or jaws?
16.	**YES**	**NO**	Are you allergic to or have you had a reaction to any medications? Please note the reaction:
	YES	**NO**	Local anesthesia?
	YES	**NO**	Penicillin or any antibiotics?
	YES	**NO**	Sulfa Drugs
	YES	**NO**	Barbiturates or sleeping pills?
	YES	**NO**	Aspirin?
	YES	**NO**	Iodine?
	YES	**NO**	Codeine or other narcotics?
	YES	**NO**	Latex or rubber products?
	YES	**NO**	List Other:
17.	**YES**	**NO**	Have you ever had any serious trouble associated with previous dental treatment? If yes, please explain:
18.	**YES**	**NO**	Do you have any other conditions or disease that you think the Doctor should know about? If yes, please explain:
19.	**YES**	**NO**	Do you smoke cigarettes, cigars, marijuana, chew tobacco or Vape? Do you use Opioids? If yes, please circle all that apply and list usage per day.
20.	**YES**	**NO**	Do you drink Alcohol? If yes, list the type of alcohol and how many drinks per week?
21.	**YES**	**NO**	Do you have a past or present chemical dependency, alcohol or emotional disorder (anxiety, depression, ADHD)? Please list:
22.	**YES**	**NO**	Are you wearing Contact Lenses?
23.	**YES**	**NO**	Are you wearing removable dental appliances?
24.	**YES**	**NO**	Are you pregnant or trying to become pregnant?
25.	**YES**	**NO**	Are you nursing?
26.	**YES**	**NO**	Do you have problems associated with your menstrual period?

Chief Dental Complaint -_____

_____

Referring Doctor -_____

I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand that it is my responsibility to fill out the form correctly and completely.

Date: _____ **Patient Signature: _____**

Doctor Signature: _____

PATIENT HEALTH HISTORY (continued)

Dental Insurance

Primary Insurance Co _____

Address _____

_____

Insured's Name _____

Insured's Birthdate_____

Insured's Employer_____

Relationship _____

Telephone number _____

Group Number _____

Social Security #/ID # _____

Medical Insurance

Primary Insurance Co _____

Address _____

_____

Insured's Name _____

Insured's Birthdate_____

Insured's Employer_____

Relationship _____

Telephone number _____

Group Number _____

Social Security #/ID # _____