David Powell, D.D.S.

Health History

(Please Print)

Name: _____

DENTAL

1. Name of previous dentist _____ Last Visit Date _____
2. Have you ever had an unusual reaction to dental anesthetic? ☐ Yes ☐ No
3. Do you have or have you ever had any of the following?

Bleeding or sore gums	☐ Yes	☐ No	Loose/shifting teeth	☐ Yes	☐ No
Unpleasant taste/bad breath	☐ Yes	☐ No	Sensitivity to hot/cold/sweets	☐ Yes	☐ No
Swelling/lumps in mouth	☐ Yes	☐ No	Sensitivity to biting or pressure	☐ Yes	☐ No
Complications from extractions?	☐ Yes	☐ No	Full or partial dentures?	☐ Yes	☐ No

4. Do you brush and floss on a routine daily basis? ☐ Yes ☐ No
5. Are you satisfied with your smile? ☐ Yes ☐ No

MEDICAL

1. Has there been any change in your general health within the past year? ☐ Yes ☐ No
2. Are you now under the care of a physician? ☐ Yes ☐ No
   If so, what is the condition?
3. The name, address and phone number of my physician is: _____
4. Have you had any serious illness within the past 5 years? ☐ Yes ☐ No
   If so, what was/is the illness? _____
5. Have you been hospitalized or had an operation within the past 5 years? ☐ Yes ☐ No
   If so, what was the reason? _____
6. Do you have or have you ever had any of the following diseases or problems:

a. Rheumatic Fever or Rheumatic Heart Disease	☐ Yes	☐ No	b. Congenital Heart Disease	☐ Yes	☐ No
c. Heart Trouble, Heart Attack, Stroke, etc.	☐ Yes	☐ No	d. High/Low Blood Pressure	☐ Yes	☐ No
e. Artificial or Replacement Heart Valves	☐ Yes	☐ No	f. Pacemaker	☐ Yes	☐ No
g. Heart Murmur	☐ Yes	☐ No	h. Allergies	☐ Yes	☐ No
i. Sinus Trouble, Asthma or Hay-Fever	☐ Yes	☐ No	j. Fainting Spells or Seizures	☐ Yes	☐ No
k. Diabetes	☐ Yes	☐ No	l. Hepatitis or Liver Disease	☐ Yes	☐ No
m. Arthritis or Inflammatory Rheumatism	☐ Yes	☐ No	n. Artificial Joint Replacement	☐ Yes	☐ No
o. Ulcers or Other Stomach Conditions	☐ Yes	☐ No	p. Kidney or Renal Disease	☐ Yes	☐ No
q. Tuberculosis, Bronchitis or Emphysema	☐ Yes	☐ No	r. Glaucoma or Cataracts	☐ Yes	☐ No
s. Thyroid Trouble	☐ Yes	☐ No	t. Allergies to Metals or Jewelry	☐ Yes	☐ No

7. Have you had abnormal bleeding associated with previous extractions, surgery or trauma? ☐ Yes ☐ No
8. Have you ever tested positive to the AIDS virus? ☐ Yes ☐ No
9. Do you have any blood disorder such as anemia, leukemia or sickle cell anemia? ☐ Yes ☐ No
10. Have you had surgery or radiation treatment for the tumor, growth or other conditions? ☐ Yes ☐ No
11. Are you taking any prescriptions, non-prescription or street drugs/medications? ☐ Yes ☐ No
    If so, explain _____
12. Have you taken in the last 4 months any of the following: (please circle) ☐ Yes ☐ No
    a. Anticoagulants (Blood Thinners), Cortisone (Steroids), Tranquilizers or Antidepressants, Aspirin, Phen Fen, Insulin or Other Diabetic Medications, Digitalis, Nitroglycerin or other Heart Medications.
13. Are you allergic or have you reacted adversely to: (please circle) ☐ Yes ☐ No
    a. Local Anesthetics, Penicillin, Sulfa Drugs, Tetracycline or other Antibiotics, Barbiturates, Sedatives or Sleeping Pills, Aspirin, Iodine, Codeine or other Narcotics?
14. Do you use tobacco in any form? ☐ Yes ☐ No
15. Are you pregnant or do you have any reason to think you may be pregnant? ☐ Yes ☐ No
16. Are you breast feeding (Nursing) ☐ Yes ☐ No
17. Are you taking birth control pills or hormone therapy? ☐ Yes ☐ No
18. Are you or have you taken Actonel, Boniva, Fosamax, Skelid, Didronel, Aredia, Zometa, Bonefos or any other bisphosphonate drugs? ☐ Yes ☐ No

(over)

Patient's Name_____

HEALTH QUESTIONNAIRE ACKNOWLEDGEMENT AND CONSENT TO PROCEED

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

I authorize Dr. David R. Powell and/or such associates or assistants as he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including, arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to, bruising, hematoma, cardiac stimulation, and temporary or rarely, permanent numbness, and muscle soreness. I understand that it is possible for needles to break during the administration of local anesthetic and that surgical recovery of the needle may be necessary.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or possibly quite painful both during and after completion of treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of the dental treatment items including, but not limited to crowns, small dental instruments, drill components, ect. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to insure safe removal.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm , if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Signature: _____ Date: _____
(Patient, legal guardian or authorized agent of patient)

Signature: _____ Date: _____
(Witness)

HISTORY UPDATE

Date _____ **Change(s):** ☐ **Yes** ☐ **No** _____

Date _____ **Change(s):** ☐ **Yes** ☐ **No** _____

Date _____ **Change(s):** ☐ **Yes** ☐ **No** _____

Date _____ **Change(s):** ☐ **Yes** ☐ **No** _____