Hastings Family Dental - (402) 462-6410 (402) 462-4463

2115 North Kansas Ave
#202
Hastings, Nebraska
68901
USA
office@hastingsdentist.com

Health History-Hastings Family Dental

Hastings Family Dental-
Medical Park-2115 N. Kansas Ave. #202, Hastings, NE 68901 Phone #:402-462-6410
West Office-2628 W. 2nd Street, Hastings, NE 68901 Phone #:402-462-5546
Doniphan Dental Services-102 S. 2nd Street, Doniphan, NE 68832 Phone #:402-845-6262

Please fill in the following information. Check any boxes that apply. If they do not apply leave the box blank. 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.

First name

Middle name

Last name

Patient date of birth

Gender

Email address

Medical Information

Allergies

- ☐ Acetaminophen/Tylenol®
- ☐ Acrylic
- ☐ Animals
- ☐ Aspirin
- ☐ Codeine
- ☐ Demerol
- ☐ Erythromycin
- ☐ Fluoride
- ☐ Food
- ☐ Hay fever/seasonal
- ☐ Ibuprofen/Motrin®/Advil®
- ☐ Iodine
- ☐ Latex
- ☐ Local anesthetic
- ☐ Metals
- ☐ Morphine
- ☐ Penicillin
- ☐ Sulfa
- ☐ Tetracycline
- ☐ Other

-

Reactions

-

Conditions

- ☐ Abnormal/excessive bleeding
- ☐ AIDS or HIV infection
- ☐ Alzheimer's/dementia
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Back problems
- ☐ Blood disease

Health History-Hastings Family Dental

- [ ] Blood transfusion
- [ ] Breathing problems/ respiratory disease
- [ ] Bronchitis
- [ ] Cancer/chemotherapy/ radiation treatment
- [ ] Cardiovascular disease
- [ ] Chest pain upon exertion
- [ ] Chronic pain
- [ ] Congestive heart failure
- [ ] Damaged heart valves
- [ ] Depression
- [ ] Diabetes
- [ ] Drug Addiction
- [ ] Eating disorder
- [ ] Emphysema
- [ ] Epilepsy
- [ ] Fainting spells or seizures
- [ ] Frequent headaches
- [ ] Gastrointestinal disease
- [ ] G.E. Reflux/persistent heartburn
- [ ] Glaucoma
- [ ] Gout
- [ ] Hearing difficulties
- [ ] Heart attack
- [ ] Heart murmur
- [ ] Heart rhythm disorder
- [ ] Hemophilia
- [ ] Hepatitis, jaundice or liver disease
- [ ] High blood pressure
- [ ] High Cholesterol
- [ ] Kidney problems
- [ ] Low blood pressure
- [ ] Low pain tolerance
- [ ] Malnutrition
- [ ] Mitral valve prolapse
- [ ] Neurological disorders
- [ ] Night sweats
- [ ] Osteoporosis/Paget's disease
- [ ] Other congenital heart defects
- [ ] Pacemaker
- [ ] Persistent swollen glands in neck
- [ ] Pre Medication
- [ ] Psychiatric care
- [ ] Recurrent Infections
- [ ] Rheumatic fever
- [ ] Rheumatic heart disease
- [ ] Rheumatoid arthritis
- [ ] Severe headaches/migraines
- [ ] Severe or rapid weight loss
- [ ] Sexually transmitted infection (STI)
- [ ] Sinus trouble
- [ ] Stroke
- [ ] Systemic lupus erythematosus
- [ ] Thyroid problems
- [ ] TMJ Disorder
- [ ] Tuberculosis
- [ ] Tumors or growths
- [ ] Ulcers
- [ ] Other

-

Details

-

Physician's Name and Phone Number:

-

Date of last physical exam

-

Preferred pharmacy

-

- [ ] Have you had a Heart Stent placed?

Health History-Hastings Family Dental

☐ Are you currently taking any medications?

-

☐ Are you currently taking blood thinners?

-

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

-

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

-

☐ Are you pregnant?

-

☐ Are you nursing?

☐ Do you have sleep apnea?

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

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

-

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

-

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

-

☐ Have you had an orthopedic total joint replacement?

-

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.

Patient Signature:

Date: