Harlan Dental Medical History Simplified

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body.
Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.
Thank you for answering the following questions.

Question			
Are you under a physician's care now?	Yes	No	If yes
Have you ever been hospitalized or had a major operation?	Yes	No	If yes
Are you taking any medications, pills, or drugs?	Yes	No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any medication containing bisphosphonates? (Osteoporosis	Yes	No	If yes
Do you use tobacco?	Yes	No	If yes
Do you bleed excessively upon injury?	Yes	No	
Do you use controlled substances?	Yes	No	If yes
Have you ever been involved with dental/medical legal activity?	Yes	No	

Women: Are you...

- ☐ Pregnant/Trying to get pregnant?
- ☐ Taking Oral Contraceptives

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Yes No	Chemo Yes No	Heart Problem Yes No	Osteoporosis Yes No
Arthritis/Gout Yes No	Diabetes I/II Yes No	Hepatitis Yes No	Rheumatic Fever Yes No
Artificial Heart Valve Yes No	Epilepsy Yes No	High Blood Pressure Yes No	STD Yes No
Artificial Joint Yes No	Glaucoma Yes No	Jaundice Yes No	Stroke Yes No
Asthma Yes No	Heart Murmur Yes No	Kidney Problems Yes No	Tuberculosis Yes No
Blood Thinners Yes No	Heart Pacemaker Yes No	Low Blood Pressure Yes No	Psychiatric Therapy Yes No
Cancer Yes No			

Have you ever had any serious illness not listed above? Yes No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:__________

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COVID-19 HEALTH SCREENING

YES	NO	Are you exhibiting symptoms of acute respiratory illness (fever, cough, shortness of breath, etc.)?
YES	NO	Have you had close contact with a laboratory confirmed COVID-19 case?
YES	NO	Have you had or been in close contact with someone hospitalized with acute lower respiratory illness of unknown origin?
YES	NO	Do you have a history of travel to or from an affected geographic area with widespread community transmission?
YES	NO	Do you have a history of international travel or cruise within the past 4 weeks?
YES	NO	Are you immunocompromised?
YES	NO	Do you now have or have you or an immediate family member been exposed to anyone with a fever, cough, cold, flu-like aches, or fatigue in the last 14 days?

Temperature: _______________ (to be taken at office)

Name ____ Date ____________

Signature ____