Preserve Parkway Dental Health History

Name_____ Preferred name:_____ DOB:_____

Address:_____ City_____ State_____ Zip_____

Best phone number to reach you:_____ Is it ok to leave a message?_____

Email:_____ Occupation:_____ Employer: _____

Emergency Contact: _____ Relationship:_____ Phone:_____

Medical History:

Primary Care Physician's Name/Location: _____ Phone:_____

Date of your last Medical Physical: _____ Women: Are you Pregnant? _____ Due Date? _____

Please circle any of the following conditions you may have:

Acid Reflux	Autism	Epilepsy	High Cholesterol	Sleep Apnea
ADD/ADHD	Asperger's	Ear problems	HIV +	Snoring
AFIB	Chemical Dependent	Hearing Impairment	High Blood Pressure	Stents/Shunts
Anemia	COPD	Heart Attack	Joint Replacement	Stroke
Angina	Cancer	Heart Disease	Kidney Disease	Thyroid
Anorexia/Bulimia	Dementia/Alzheimer's	Heart Failure	Liver Disease	Tuberculosis
Anxiety	Depression	Heart Murmur	Pacemaker	TMJ
Arthritis	Diabetes	Heart Valve Surgery	Sinus Problems	Other_____
Asthma	Dry Mouth	Hepatitis	Seizures	_____

Please list any **SURGERIES** in the last ***TWO*** years? _____

Do you take **ANTIBIOTIC PREMEDICATION** *prior* to dental appointments? _____

Please list all **ALLERGIES** you have: _____ ***I'm not allergic to anything*** _____

Do you use **TOBACCO** PRODUCTS (*including E-Cigs/vaping*)?_____

Do you ***or*** have you taken any **MEDICATIONS FOR OSTEOPOROSIS**?_____

Please list of *all* **MEDICATIONS** you are taking ***(****including Vitamins & Aspirin).* ***I don't take any medications*** _____

_____

Signature of Patient: _____ Date:_____

(if Minor, Parent or Guardian please sign):_____ Date: _____

DDS signature:_____ Summary:_____Date:_____