C2 Dentistry
28212 Kelly Johnson Pkwy. Suite 180 Valencia, CA 91355 t: 661-702-0940 f: 661-702-0941 www.c2dental.com

Patient Health History

Answers to the following questions are for our record only and will be considered confidential

1. Date of last physical examination:__________Physician's Name:__________________
2. Is there anything you would like to speak with the Doctor about in private? ☐ Yes ☐ No
3. Have you been hospitalized in the past 2 years? ☐ Yes ☐ No
4. Have you take any medications or drugs in the past 2 years? ☐ Yes ☐ No
5. Have you ever taken Redux of Pondimin (Fen Phen)? ☐ Yes ☐ No
6. Please list current medications that you are taking:

____

____

Allergies

Aspirin:	☐ Yes ☐ No	Local Anesthesia:	☐ Yes ☐ No	Codeine:	☐ Yes ☐ No
Iodine:	☐ Yes ☐ No	Barbiturate:	☐ Yes ☐ No	Sulfa:	☐ Yes ☐ No
Penicillin:	☐ Yes ☐ No	Erythromycin:	☐ Yes ☐ No	Latex:	☐ Yes ☐ No
Metals:	☐ Yes ☐ No	Other:________________________________			

Please indicate if you have had any of the following:

Alcoholism	☐ Yes ☐ No	Artificial Joints	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
Angina Pectoris	☐ Yes ☐ No	Birth Defects	☐ Yes ☐ No
Any Transplant	☐ Yes ☐ No	Blood Transfusion	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Bruise Easily	☐ Yes ☐ No
Drug Addiction	☐ Yes ☐ No	Cancer	☐ Yes ☐ No
Eating Disorder	☐ Yes ☐ No	Chemotherapy	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Chest Pains	☐ Yes ☐ No
Epilepsy/Seizures	☐ Yes ☐ No	Cold Sores	☐ Yes ☐ No
Fainting/Dizziness	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	Hives or Skin Rash	☐ Yes ☐ No
Hay Fever	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No
Heart Attack	☐ Yes ☐ No	Herpes Simplex	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No
Hear Surgery	☐ Yes ☐ No	Hepatitis A/B/C	☐ Yes ☐ No

Condition	Yes	No	Condition	Yes	No
Dentures/Partials	☐ Yes	☐ No	Radiation Therapy	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Jaundice	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Kidney Problems	☐ Yes	☐ No	Sickle Cell Anemia	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No	Steroid Treatment	☐ Yes	☐ No
Mental Retardation	☐ Yes	☐ No	Stroke (CVA)	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No	Tobacco Use	☐ Yes	☐ No
Persistent Cough	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Psychiatric Therapy	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No

Have you ever experienced any of the following problems with your jaw?

- Clicking/ Clenching/ Grinding ☐ Yes ☐ No
- Pain in or around ears and/or headaches ☐ Yes ☐ No
- Difficulty opening, closing, or chewing ☐ Yes ☐ No
- Do you have history of trauma to your jaw ☐ Yes ☐ No
- Have you ever been diagnosed with TMJ/TMD ☐ Yes ☐ No

Do you have any of the problems listed below?

- Swelling/ Bleeding Gums ☐
- Bad taste (Halitosis) ☐
- Loose Teeth ☐

Do you have sensitivity to:

- Temperature (Hot or Cold) ☐
- Biting/ Pressure ☐
- Sweet/ Tart Flavors ☐

- Have you ever had any sores, lumps or growths in or near your mouth? ☐ Yes ☐ No
- Have you ever had prolonged bleeding following extractions? ☐ Yes ☐ No
- Does food collect between your teeth? ☐ Yes ☐ No
- Have you ever needed to see a Periodontist (Gum specialist)? ☐ Yes ☐ No
- Do you now have any bleeding gums or any other gum conditions? ☐ Yes ☐ No
- Are you having pain or discomfort at this time? ☐ Yes ☐ No
- Do you feel nervous about having dental treatment? ☐ Yes ☐ No
- Have you ever had a bad experience in a dental office? ☐ Yes ☐ No
- Have you ever been told that you snore while sleeping? ☐ Yes ☐ No

28212 Kelly Johnson Pkwy. Suite 180 Valencia, CA 91355 t: 661-702-0940 f: 661-702-0941 www.c2dental.com

Is there anything related to your medical and/or dental history that you have not indicate above?

____

____

<u>For Women:</u>

Are you currently taking oral contraceptives?	☐ **Yes**	☐ **No**
Are you pregnant now?	☐ **Yes**	☐ **No**
If yes, when is your due date?____________		
Are you currently breast feeding?	☐ **Yes**	☐ **No**

I certify that I have read and understood the above information, and that the above questions have been accurately answered to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information (including diagnosis and records of any treatment or examination rendered to me or my child) to third party payers and/or healthcare practitioners. I authorize and request my insurance company to directly reimburse the dentist or dental group any benefits otherwise payable to me. I agree to be responsible for payment of all services rendered on by behalf, or on behalf of my dependents.

X____

Signature of Patient or Guardian **Date**

X____

Signature of Dentist **Date**