**Patient Health History**

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Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

Current Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home # (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell # (\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you being treated by a physician for any **NEW OR EXISTING** medical conditions? If yes please explain below:

|  |
| --- |
|  |

|  |  |
| --- | --- |
| Please list any **medications** you are currently taking: | Please list any known **allergies** |
| * \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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 |

Do you have any of the following conditions? Please check all that apply:

|  |  |
| --- | --- |
| * Arthritis/Rheumatism
* Asthma
* Congestive Heart Failure (CHF)
* COPD
* Diabetes
* Hepatitis
* High Blood Pressure
 | * HIV/AIDS
* Kidney Disease
* Liver Disease
* Pacemaker
* Seizures
* Tuberculosis
* Ulcers
 |

Have you received a COVID-19 vaccination? If yes, when (month/year) and what vaccine did you receive?

**🞎 Yes 🞎 No Date: \_\_\_\_/\_\_\_\_\_\_\_\_**

**🞎 Pfizer-BioNTech 🞎 Moderna 🞎 Johnson & Johnson**

Have you ever tested positive for any of the following illnesses/diseases?

**🞎 COVID-19 🞎 HIV/AIDS 🞎 Hepatitis B 🞎 Hepatitis C 🞎 MRSA 🞎 C. diff**

Have you had any artificial joint or valve replacements? **🞎 Yes 🞎 No**

If yes, what was the date of the replacement (month/year)? \_\_\_/\_\_\_\_\_\_

**Has your physician advised you to pre-medicate with an antibiotic prior to dental treatment?**

**🞎 Yes 🞎 No**

Do you use any of the following? (Please check all that apply)

🞎 Tobacco/Vaporizers/E-Cigarettes How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞎 Caffeine How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞎 Alcohol How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you employed in any situation that regularly exposes you to x-rays or radiation?

**🞎 Yes 🞎 No**

Are you pregnant?

**🞎 Yes 🞎 No**

How often do you brush? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use any of the following? (Please check all that apply):

**🞎 Toothbrush 🞎 Floss 🞎 Fluoride Rinse 🞎 Other \_\_\_\_\_\_\_\_\_\_\_**

Do you regularly receive dental cleanings? **🞎 Yes 🞎 No**

If not, when was the date of your last dental visit: \_\_\_/\_\_\_/\_\_\_\_\_\_

Have you ever been treated for periodontal diseases such as gum disease, pyorrhea, or trench mouth, etc.?

**🞎 Yes 🞎 No**

Do you have any of the following dental issues? (Please check all that apply):

|  |  |
| --- | --- |
| * Bad breath
* Bleeding gums
* Braces or other orthodontics
* Burning tongue/lips
* Clicking, popping, or clenching jaw
* Difficulty opening or closing jaw
 | * Food impaction
* Frequent mouth or gum blisters/sores
* Teeth grinding
* Loose teeth
* Sensitive to cold, hot, or sweet
* Sensitive when biting
 |

**Emergency Contact**:Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- |
| *I authorize the dental staff of this office to perform any services deemed necessary during the phases of diagnosis and treatment. In the event that a staff member has an accidental exposure, I give my permission for the office to contact my medical doctor for any medical records necessary.**I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.*Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_ |