Hastings Family Dental
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(402) 462-4463
2115 North Kansas Ave
#202
Hastings, Nebraska
68901
USA
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Health History -HFD

Please fill in the following information. 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 birth date

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
- ☐ 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
- [ ] Diabetes
- [ ] 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
- [ ] 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
- [ ] 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

-

- [ ] Are you currently taking any medications?

-

- [ ] Are you currently taking any 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® 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.

Signature

I agree that the information provided in this form is correct to the best of my knowledge.