UDA
University Dental Associates
Modern Dentistry with a Gentle Touch

Patient Information • Health History Part 2

Patient Name____

	Y	N		Y	N		Y	N
Thyroid Issues			Tumor/Cancer			Reaction to Anesthesia		
Diabetes			Radiation or Chemotherapy			Frequent Cold Sores		
Low Blood Sugar			Blood Transfusion			Do You Drink Alcohol		
Kidney Trouble			Eye Disease/Glaucoma			Do You Use Addictive Drugs		
Are you receiving dialysis			Depression/Mental Health Issues			Blood Thiners/Aspirin		
Arthritis/Joint Issues			Do You Wear Contacts			Cortisone		
Prosthetic (artificial) Joint Replacement			Pain of Clicking in The Jaw			Tranquillizers/Sleeping Pills		
Sexually Transmitted Disease/AIDS/HIV			Malignant Hyperthemia			Do You Smoke		

Please list any medications you're allergic to:	Please list any medicatons you're taking:

Women - is there any possibility you're pregnant Yes ( ) No ( ) Nursing Yes ( ) No ( ) Birth Control Yes ( ) No ( )

Is there any other condition we should be made aware of Yes ( ) No ( ) If yes, explain____________________________

Primary Physician____________________________________Telephone____________________

I hereby certify that I have read and understand the above. I acknowledge that my answers regarding health history have been answered to my satisfaction. I will not hold my surgeon or any member of his staff responsible for any errors or omissions that I have made in completing this form.

Patient Signature____Date__________________