

# Gateway Dental

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## HEALTH HISTORY

### HEALTH INFORMATION

PLEASE PRINT

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

If completing this form for another person, what is your name and relationship to that person?  
\_\_\_\_\_

Is there anything you wish to discuss in private with the doctor? Yes \_\_\_\_\_ No \_\_\_\_\_

For the following questions, **circle Yes or No**. Your answers are for our records only and will be kept confidential.

- |  |  |
|--|--|
| <p>1. Are you in good health? ..... Yes No</p> <p>2. Has there been any change in your general health within the past year? ..... Yes No</p> <p><b>Have you ever had or do you now have?</b></p> <p>3. Pacemaker ..... Yes No</p> <p>4. Heart Murmur ..... Yes No</p> <p>5. Mitral valve prolapse ..... Yes No</p> <p>6. Rheumatic heart disease ..... Yes No</p> <p>7. Damaged heart valve ..... Yes No</p> <p>8. Heart trouble ..... Yes No</p> <p>9. Heart attack ..... Yes No</p> <p>10. Angina ..... Yes No</p> <p>11. High Blood Pressure ..... Yes No</p> <p>12. Arteriosclerosis (hardening of the arteries) ..... Yes No</p> <p>13. Stroke ..... Yes No</p> <p>14. Chest pain upon exertion ..... Yes No</p> <p>15. Shortness of breath after mild exercise or when lying down? ..... Yes No</p> <p>16. Swollen ankles ..... Yes No</p> <p>17. Congenital heart defect ..... Yes No</p> <p>18. Prosthetic (artificial) heart valve ..... Yes No</p> <p>19. Allergy ..... Yes No</p> <p>20. Sinus trouble ..... Yes No</p> <p>21. Asthma or hay fever ..... Yes No</p> <p>22. Fainting spells or seizures ..... Yes No</p> <p>23. Persistent diarrhea or recent weight loss ..... Yes No</p> <p>24. Diabetes ..... Yes No</p> <p>25. Hepatitis, jaundice or liver disease ..... Yes No</p> <p>26. AIDS or HIV infection ..... Yes No</p> <p>27. Thyroid problems ..... Yes No</p> <p>28. Respiratory problems, emphysema, bronchitis, etc. .... Yes No</p> | <p>29. TB, Tuberculosis (Self, Family, Household) ..... Yes No</p> <p>30. Persistent cough/ cough that produces blood ..... Yes No</p> <p>31. Arthritis or painful/swollen joints ..... Yes No</p> <p>32. Artificial joint replacement ..... Yes No</p> <p>33. Stomach ulcer or hyperacidity ..... Yes No</p> <p>34. Kidney trouble or dialysis ..... Yes No</p> <p>35. Persistent swollen glands in neck ..... Yes No</p> <p>36. Sexually transmitted disease ..... Yes No</p> <p>37. Epilepsy or other neurological disease ..... Yes No</p> <p>38. Psychotherapy ..... Yes No</p> <p>39. Problems with mental health ..... Yes No</p> <p>40. Cancer ..... Yes No</p> <p>41. Problems of the immune system ..... Yes No</p> <p>42. Rheumatic fever or scarlet fever ..... Yes No</p> <p>43. Abnormal bleeding ..... Yes No</p> <p>44. Blood transfusion ..... Yes No</p> <p>45. Blood disorders such as anemia ..... Yes No</p> <p>46. Tumor or growth ..... Yes No</p> <p>47. Allergic or other reaction to</p> <p style="padding-left: 20px;">a. local anesthetics or dental anesthetics .... Yes No</p> <p style="padding-left: 20px;">b. Penicillin or other antibiotics ..... Yes No</p> <p style="padding-left: 20px;">c. Sulfa drugs ..... Yes No</p> <p style="padding-left: 20px;">d. Barbiturates, sedatives, or sleeping pills ... Yes No</p> <p style="padding-left: 20px;">e. Aspirin ..... Yes No</p> <p style="padding-left: 20px;">f. Codeine ..... Yes No</p> <p style="padding-left: 20px;">g. Other ..... Yes No</p> <p><b>Women</b></p> <p>48. Are you pregnant? ..... Yes No</p> <p>49. Do you have any problems associated with your menstrual period? ..... Yes No</p> <p>50. Are you nursing? ..... Yes No</p> |
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Please explain YES answers above and list serious illnesses, operations and hospitalizations within past five years:  
\_\_\_\_\_

Are you taking any medications (including non prescription)? \_\_\_\_\_

Tobacco use: Current Past Never used Type \_\_\_\_\_ Amount per day \_\_\_\_\_ Date tobacco use stopped \_\_\_\_\_

Alcohol use: Current Past Never used Describe usage:  
\_\_\_\_\_

Names of your primary health care practitioners (MD, DC, DO, etc.):

Name \_\_\_\_\_ Specialty \_\_\_\_\_ City \_\_\_\_\_

Name \_\_\_\_\_ Specialty \_\_\_\_\_ City \_\_\_\_\_

Are you now under the care of a doctor? Yes No If Yes, what is the condition being treated?

\_\_\_\_\_

I certify that I have read and understood the above. I acknowledge that any questions I had about the inquiries above have been answered to my satisfaction. I will not hold my dentist, or any member of his staff, responsible for any errors that I may have made in the completion of this form.

\_\_\_\_\_  
SIGNATURE OF PATIENT, PARENT OR GUARDIAN

\_\_\_\_\_  
Date