

Nancy H. Holm, D.D.S.
HEALTH HISTORY

1. Are you having pain of discomfort at this time? Yes No
2. Do you feel very nervous about having dental treatment? Yes No
3. Have you ever had a bad experience in the dental office? Yes No
4. Have you been a patient in the hospital during the past two years? Yes No
Why? _____
5. Have you been under the care of a medical doctor during the past two years? Yes No
Physician's Name: _____
Address: _____ Phone: _____
6. Have you taken any medicine or drugs during the past two years? Yes No
Are you NOW taking any medication, drugs or pill? Yes No
If yes, please list: _____
7. Are you allergic or have you reacted adversely to any of the following medications?
 Aspirin Nitrous Oxide Valium Local Anesthetic
 Darvon Erythromycin Scopolamine (Novocaine or Xylocaine)
 Codeine Tetracycline Penicillin Sleeping Pills
 Demerol Percodan Other Antibiotics (Nembutal / Seconal)
8. Are you aware of being allergic to any other medications or substance? Yes No
If yes, please list: _____
9. Have you had or do you have at present any of the following? Please check Yes or No
- | | | |
|---|---|---|
| Heart Failure..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema..... <input type="checkbox"/> Yes <input type="checkbox"/> No | AIDS / HIV / ARC <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Disease or Attack..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Cough..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis A (infectious)..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Angina Pectoris..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis (TB)..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis B (serum)..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High Blood Pressure..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis C <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Murmur..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Hay Fever..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Rheumatic Fever..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Yellow Jaundice..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Lesions..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Allergies or Hives..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood Transfusion..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Scarlet Fever..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Drug Addition..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valve..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Pacemaker..... <input type="checkbox"/> Yes <input type="checkbox"/> No | X-ray or Cobalt Treatment..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Veneral Disease (Syphilis, Gonorrhea)..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Surgery..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Chemotherapy (Cancer, Leukemia)..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Cold Sores..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints (Hip, Knee)..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Arthritis..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Fever Blisters..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatism..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy or Seizures..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stroke..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Cortisone Medicine..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting or Dizzy Spells..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Kidney Trouble..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervousness..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Ulcers..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Pain in Jaw Joints..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Treatment..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cosmetic Surgery..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Bruise Easily..... <input type="checkbox"/> Yes <input type="checkbox"/> No | Sickle Cell Disease..... <input type="checkbox"/> Yes <input type="checkbox"/> No |
10. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest or shortness of breath, or because you are very tired? Yes No
11. Do your ankles swell during the day? Yes No
12. Do you use more than 2 pillows to sleep?..... Yes No
13. Have you lost or gained more than 10 pounds in the past year? Yes No
14. Do you ever wake up from sleep short of breath? Yes No
15. Are you on a special diet?..... Yes No
16. Has your medical doctor ever said you have a cancer or tumor?..... Yes No
17. Do you have any disease, condition or problem not listed?..... Yes No
If yes, please list: _____

FOR WOMEN ONLY:

Are you pregnant?..... Yes No If yes, what month? _____ Are you taking birth control pills Yes No

THE ABOVE INFORMATION IS TRUE

Patient or Parent Signature _____ Date _____

CONSENT:

The undersigned hereby authorizes Dr. Nancy H. Holm to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Nancy H. Holm to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Nancy H. Holm to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient) _____ and further authorize and consent that Dr. Nancy H. Holm choose and employ such assistance as she deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. In consideration of services provided, I am agreeing to pay for services provided to me, to my spouse and to my minor children. I/we agree to pay all charges not covered by insurance. I further understand that **A FINANCE CHARGE** may be computed on the unpaid balance 60 days and over. The maximum periodic rate and **ANNUAL PERCENTAGE RATE** are determined by the laws of the patient's state of residence. In the event a **FINANCE CHARGE** may be made on your account, the periodic rate and the **ANNUAL PERCENTAGE RATE** appear in the lower right corner of the form of your statement. In the event of default, I/we promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note. VISA, Mastercard and Discovery accepted.

Patient _____ Date _____ Witness _____

or
Parent or Responsible Party _____ Relationship to Patient _____

