Fonseca Dentistry
John F. Fonseca, D.D.S.

Health History

Patient Name: _____

Please check for any of the following which may apply to you now or in the past:

☐Heart attack / Chest Pain	☐ Implant or Artificial Joint	☐Thyroid Disease	☐ Headaches or Migraines
☐Heart Disease	When? _____	☐Asthma	☐Epilepsy or Seizures
☐Pacemaker	☐Anemia or Blood Disorder	☐Ulcers, Reflux, Heartburn	☐Cancer, Chemo, Radiation
☐Heart Valve Disorder	☐Excessive Bleeding	☐Digestive Disorders	☐Tuberculosis, Lung Problems
☐Stroke	☐Psychiatric Disorders	☐Kidney or Liver Problems	☐Hepatitis A B C D
☐ High Blood Pressure	☐Mononucleosis	☐Fainting or Blackouts	☐AIDS or HIV Infection
☐Diabetes	☐Herpes	☐Drug/Alcohol Dependency	☐Use Tobacco?

Has your physician advised you to take antibiotics before dental treatment? ☐ Y ☐ N Reason_____

Periodontal disease has been linked to the following; do you have any family history of: (check any that apply)

☐Heart Disease ☐Stroke/Diabetes ☐Early-Term Birth ☐Cancer ☐Dementia

(Women) Are you currently pregnant? _____ If yes, when are you expecting? _____

Have you had any surgeries or been hospitalized in the last 5 years? ☐ Y ☐ N

If yes, please explain: _____

Physician's name and phone: _____

Please list any **allergic reactions** to an anesthetic or drug such as **penicillin, sedatives, latex, aspirin, or metals**:

_____

Please list any drugs, medications, or vitamins you are currently taking:

We offer a variety of services to enhance your comfort and keep your smile beautiful. Please check any service below you would like our friendly team to discuss with you during your visit:

☐ Whitening/Bleaching	☐ Anxiety	☐ Clear braces to straighten teeth
☐ Traditional Braces	☐ Veneers	☐ Extended Payment Plans
☐ Implants to Replace Missing Teeth	☐ Night guards	☐ Sports mouth guard

I have reviewed all questions and answered them to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. If I have a change in my health, I will inform the doctor at the next appointment.

Responsible Party Signature: _____ Date: _____

Doctor/Hygienist Signature: _____ Date: _____