

**HARBOR SQUARE DENTAL**  
**Nicole Serra, DDS & Amy Winter, DDS**  
**(425) 778-7477**

**Health History**

Patients Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Physician's Name \_\_\_\_\_ Physician's Phone# (\_\_\_\_) \_\_\_\_\_

Please list all **MEDICATIONS & reasons for use** (including herbal/natural remedies):

\_\_\_\_\_

Have you ever been advised to take antibiotics prior to a dental cleaning? YES NO

**Please circle** if you have or have had any of the following:

**HEART**

Heart Attack  
Heart Surgery  
Heart Murmur  
Mitral Valve prolapse  
Congenital Heart Defects  
Pacemaker/Defibrillator  
Artificial heart valve  
Angina/chest pain  
High blood pressure  
Low blood pressure  
Rheumatic fever

**BLOOD**

Easy Bruising  
Frequent nosebleeds  
Abnormal bleeding  
Blood Disease  
History of blood transfusion

**ALLERGY**

Hay fever  
Sinus problems  
Skin rashes  
Take allergy meds  
Asthma  
**DIGESTIVE**  
Ulcers  
Special diet  
Constipation/diarrhea  
Kidney Problems  
Bladder Problems  
Weight gain or loss  
Acid Reflux

**BONE/JOINT**

Arthritis/ Rheumatoid  
Back/Neck Pain  
Joint replacement

**NERVOUS SYSTEM**

Seizures  
Epilepsy  
History of head injury  
Other:

**DIABETES**

Type 1 or 2 Diabetes  
Family History of diabetes  
Urinate more than 6x/day  
Thirsty frequently  
Controlled with medication

**CANCER**

Type: \_\_\_\_\_  
Stage: I II III IV  
In Remission  
Chemotherapy

**Other Conditions**

Autoimmune disorder  
Stroke  
Thyroid disorder  
Frequent/severe headaches  
Eating disorder  
Tuberculosis  
Hepatitis A  
Hepatitis B or C  
Liver disease  
Cold sores  
Other STDs \_\_\_\_\_  
HIV positive/ AIDS  
Glaucoma  
Alcoholism  
Drug Addiction  
Smoke \_\_\_\_\_ packs a day  
Behavioral Disorder  
Special Needs Issues

Please list any other medical conditions you have ever had that are not listed above. \_\_\_\_\_

Have you been hospitalized for any reason within the last year? **YES NO** If yes please describe \_\_\_\_\_

\_\_\_\_\_

**Do you have allergies to any of the following? Please circle:**

**Antibiotics Aspirin Barbiturates Codeine Iodine Latex Local Anesthetic Sulfa Other** \_\_\_\_\_

Please describe your reaction: \_\_\_\_\_

**WOMEN:**

Are you pregnant? **YES NO** Due Date: \_\_\_\_\_ Are you nursing? **YES NO**

Are you taking birth control pills? **YES NO**

(Please note that some antibiotics may interfere with the effectiveness of birth control pills and a second form of birth control should be used If antibiotics are prescribed).

**To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.**

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

\_\_\_\_\_ **Provider Initials** \_\_\_\_\_