W A (DREW) SCHOLTZ DDS PLC

2015 Holton Rd.
Muskegon, MI. 49445
231-744-4784

Patient Information

Patient Name____Birth Date:__________________________
Last, First MI (Preferred Name)

If new patient: Date of Last Dental Visit:_______________ Reason for this visit:__________________________

Health Information

Name of Physician________________________________**Physician Phone number**________________________________

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Thyroid problems
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints (year) ____________
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer/when______ kind__________ ______
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Artificial Heart Valves
- ☐ Mitral Valve Prolapse
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Intravascular Devices
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ **Pregnancy** Due date:__________
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ SLE(Lupus)
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease

ALLERGIES

- ☐ Codeine Allergy
- ☐ Latex Allergy
- ☐ Metal Allergy (jewelry)
- ☐ Penicillin Allergy
- ☐ Other ______________ ______________________

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: ____
- **Have you ever taken a medication for increasing bone density?** ☐ Yes ☐ No
  If yes, which one(s) ______________________________and for how long?__________________________
- Do you smoke?_______If yes, how much?____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ____
- Do you use herbal supplements? If so, which ones?____
- ***Women note:*** *Antibiotics may alter the effectiveness of birth control pills. Consult your physician for assistance regarding additional methods of birth control when being treated with antibiotics.*

Medication List

Please list any medications you are currently taking:____
____
____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____ Date_______________Documented by __________/_________________
Signature of patient, parent or guardian

Changes______________________________Date_________Patient/Guardian_______________Documented by_____/_______

Changes______________________________Date_________Patient/Guardian_______________Documented by_____/_______

Changes______________________________Date_________Patient/Guardian_______________Documented by_____/_______