Flourish Dental Boutique
1415 State St #800, Richardson, TX 75082
(469) 676 2777
www.flourish.dental

HEALTH HISTORY
| DOB:

Summary

Medical Conditions	**none listed**
Allergies	**none listed**
Medications	**none listed**

General Health Information

Are you currently under the care of a physician?	
Who are the healthcare or holistic providers you currently (within the last 12 months) see? (Ie, physician, chiropractor, naturopath, nurse practitioner, homeopath, acupuncturist, etc.)	
Are you presently being treated for any injury or illness?	
Have you ever been hospitalized for an injury or illness?	
What is the name and location of your preferred pharmacy?	
Are you pregnant or planning to become pregnant?	
Are you currently breastfeeding?	
Are you required to pre-med with antibiotics before dental treatment?	
Do you use alcohol?	
Do you use or have you ever used tobacco?	
Have you ever had an allergic reaction?	

Medical Conditions

Please check all conditions that you have history of or are currently being treated for	
Do you have a history or are currently being treated for any Digestive conditions?	
Do you have a history or are currently being treated for any Heart or Circulatory conditions?	
Do you have a history or are currently being treated for any Neurological conditions?	
Do you have a history or are currently being treated for any Lung or Breathing conditions?	
Do you have a history or are currently being treated for any Autoimmune conditions?	
Head or neck injuries?	
Artificial Joint?	
High cholesterol?	
History of cancer?	
Tumor or abnormal growth?	
Radiation therapy?	
Chemotherapy?	
HIV / AIDS?	
Osteoporosis / osteopenia?	

Type I or Type II diabetes?	
Anemia?	
Kidney disease?	
Liver disease?	
Thyroid disease?	
Tuberculosis / measles / chicken pox?	
Any other medical condition we should know of?	
Do you snore?	
Has someone observed you stop breathing while sleeping?	
Do you often feel tired during the day?	
Have you been diagnosed with sleep apnea?	
Have you had any vaccinations/injections/shots/boosters designed for the prevention of COVID-19?	

Medications

Please check all medications you are currently taking	
Are you taking any pain medications?	
Are you taking any Antidepressants or Anxiety medications?	
Are you taking any Diabetes, Cholesterol, or Blood Pressure medications?	
Are you taking any Allergy or Asthma medications?	
Are you taking any Antibiotics?	
Are you currently taking any other medications or dietary supplements?	

Patient's signature: Date:

Doctor's signature: Date: