HEALTH HISTORY

Patient Name: _____ Date of Birth: _____

Current Address: _____ Current Phone Number: _____

DENTAL HISTORY

Reason for Today's Visit: _____ Date of last dental care: _____

*Mark (**X**) If you have had problems with any of the following:*

☐ Bad Breath	☐ Food collection between teeth	☐ Periodontal treatment	☐ Sensitivity to hot
☐ Bleeding gums	☐ Grinding teeth	☐ Sores or growth in mouth	☐ Sensitivity to cold
☐ Clicking or popping of jaw	☐ Loose teeth or broken fillings	☐ Sensitivity when biting	☐ Sensitivity to sweet

How often do you floss? _____ *How often do you brush?* _____

MEDICAL HISTORY

Physician's Name (PCP): _____ Date of last visit: _____

Have you had any serious illnesses or operations? If yes, please list with procedure and date: _____

_____

Have you ever had a blood transfusion? If yes, please list dates: _____

Have you taken any group of drugs collectively referred to as "Fen-phen"? These include combinations of Lonimin, Adipex, Fastine (brand names of Phentermine), Pondimin (Fenfluramine) and Redux (Dexfenfluramin). ☐ Yes ☐ No

Do you or have used Bisphosphonate medication (Fosomax, Actonel, Boniva, Skelid, Didronel, Aredia, Zometa, Bonefos)? ☐ Yes ☐ No

[Women] *Are you pregnant?* ☐ Yes ☐ No *Nursing?* ☐ Yes ☐ No *Taking Birth Control Pills?* ☐ Yes ☐ No

*Mark (**X**)if you have or have had any of the following :*

☐ Abnormal Bleeding	☐ Cortisone Treatments	☐ Hepatitis (A, B, C or other): _____	☐ Rheumatic Fever
☐ Anemia	☐ Cough (Persistent)	☐ High Blood Pressure	☐ Scarlet Fever
☐ Arthritis, Rheumatism	☐ Cough up blood	☐ HIV/AIDS	☐ Skin Rash
☐ Artificial Heart Valves	☐ Dementia/Alzheimer's	☐ Jaw Pain	☐ Shortness of Breath
☐ Artificial Joints: _____	☐ Diabetes	☐ Kidney Disease	☐ Sinus Problems
☐ Asthma	☐ Dialysis	☐ Liver Disease	☐ Stroke
☐ Anxiety/Nervousness	☐ Difficulty breathing	☐ Mental Health Treatment	☐ Swelling of Feet
☐ Blood Disease	☐ Epilepsy	☐ Mitral Valve Prolapse	☐ Thyroid Problems
☐ Cancer	☐ Fainting	☐ Numbness or Muscle Weakness	☐ Tobacco Habit
☐ Chemical Dependency	☐ Glaucoma	☐ Organ Transplant	☐ Tonsillitis
☐ Chemotherapy	☐ Headaches	☐ Pacemaker	☐ Tuberculosis
☐ Circulatory Problems	☐ Heart Murmur	☐ Radiation Treatment	☐ Ulcer
☐ Cold Sores/Canker Sores	☐ Heart Problems	☐ Respiratory Disease	☐ Venereal Disease

******Do you have any other medical conditions not already listed above?*** _____

MEDICATIONS

List of current medications:

_____

_____

ALLERGIES

☐ Aspirin	☐ Latex
☐ Barbiturates	☐ Metals/Nickels/Jewelry
☐ Codeine	☐ Penicillin/Other Antibiotic _____
☐ Dental Anesthetic	☐ Sulfa Drugs
☐ Iodine	☐ Other: _____

SOCIAL

Do you use alcohol? ☐ Yes- How often? _____ ☐ No Do you use recreational drugs? ☐ Yes- How often? _____ ☐ No

SIGNATURE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____ _____

Signature of Patient, Parent, Guardian or Personal Representative *Relationship to Patient* *Date*