

## Health History

Patient Name: \_\_\_\_\_

Indicate which of the following you have had or have at the present? Please check those that apply:

	Yes	No		Yes	No		Yes	No
AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
Allergy to Latex	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Due Date _____		
Angina Pectoris	<input type="checkbox"/>	<input type="checkbox"/>	Fever blisters	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Allergy to metal (jewelry, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin Allergy	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Radiation treatment	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis/Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory problems	<input type="checkbox"/>	<input type="checkbox"/>
Arteriosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	Head Injuries	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>	Hives	<input type="checkbox"/>	<input type="checkbox"/>	Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Rods or Pins	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Stomach problems	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease or attack	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>	H.I.V. Positive	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A (infectious)	<input type="checkbox"/>	<input type="checkbox"/>	Tumors	<input type="checkbox"/>	<input type="checkbox"/>
Cold sores	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B (Serum)	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Codeine Allergy	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone medication	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis medications		
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Fosomax or	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Kidney transplant	<input type="checkbox"/>	<input type="checkbox"/>	Bonine	<input type="checkbox"/>	<input type="checkbox"/>
or Dialysis			Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Others Not Listed	<input type="checkbox"/>	<input type="checkbox"/>
Drug addiction	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disorders	<input type="checkbox"/>	<input type="checkbox"/>			
Embolism	<input type="checkbox"/>	<input type="checkbox"/>	Mental Disorders	<input type="checkbox"/>	<input type="checkbox"/>			
			Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>			

When was your last Dental Exam? \_\_\_\_\_

When was your last full mouth x-rays? \_\_\_\_\_

Have you had to take **antibiotics** before any dental treatment?  Yes  No If so why? \_\_\_\_\_

Have you ever had any complications following dental treatment?  Yes  No  
If yes, please explain: \_\_\_\_\_

Are you sensitive or allergic to any medication or anesthetics?  Yes  No If yes, please list: \_\_\_\_\_

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: \_\_\_\_\_  
Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you have any health problems that need further clarification?  Yes  No  
If yes, please explain: \_\_\_\_\_

List all medications you are currently taking: \_\_\_\_\_

Have you ever taken appetite suppressants - fen-phen (Fenluramine & Phentermine) or dexenflurameine?  Yes  No

Have you been under the care of a medical doctor during the last two years or since taking any of the appetite suppressants named above?  Yes  No If yes, Physicians Name: \_\_\_\_\_ Phone#: \_\_\_\_\_

**For Women Only:** Are you taking birth control?  Yes  No If yes, patient has to seek other methods of contraceptives while Taking antibiotics, or risk pregnancy.

