HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. Yes ☐ No ☐

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combination of Ionimin, Adipex, Fastin (brand names for phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes ☐ No ☐

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	Yes ☐ No ☐	Epilepsy	Yes ☐ No ☐	Respiratory Disease	Yes ☐ No ☐
Anemia	Yes ☐ No ☐	Fainting or dizziness	Yes ☐ No ☐	Rheumatic Fever	Yes ☐ No ☐
Arthritis, Rheumatism	Yes ☐ No ☐	Glaucoma	Yes ☐ No ☐	Scarlet Fever	Yes ☐ No ☐
Artificial Heart Valves	Yes ☐ No ☐	Headaches	Yes ☐ No ☐	Shortness of Breath	Yes ☐ No ☐
Artificial Joints	Yes ☐ No ☐	Heart Murmur	Yes ☐ No ☐	Sinus Trouble	Yes ☐ No ☐
Asthma	Yes ☐ No ☐	Heart Problems	Yes ☐ No ☐	Skin Rash	Yes ☐ No ☐
Back Problems	Yes ☐ No ☐	Hepatitis Type ____	Yes ☐ No ☐	Special Diet	Yes ☐ No ☐
Bleeding Abnormally, with		Herpes	Yes ☐ No ☐	Stroke	Yes ☐ No ☐
extraction or surgery	Yes ☐ No ☐	High Blood Pressure	Yes ☐ No ☐	Swollen Feet or Ankles	Yes ☐ No ☐
Blood Disease	Yes ☐ No ☐	Jaundice	Yes ☐ No ☐	Swollen Neck Glands	Yes ☐ No ☐
Cancer	Yes ☐ No ☐	Jaw Pain	Yes ☐ No ☐	Thyroid Problems	Yes ☐ No ☐
Chemical Dependency	Yes ☐ No ☐	Kidney Disease	Yes ☐ No ☐	Tonsillitis	Yes ☐ No ☐
Chemotherapy	Yes ☐ No ☐	Liver Disease	Yes ☐ No ☐	Tuberculosis	Yes ☐ No ☐
Circulatory Problems	Yes ☐ No ☐	Low Blood Pressure	Yes ☐ No ☐	Tumor or growth on head	
Congenital Heart Lesions	Yes ☐ No ☐	Mitral Valve Prolapse	Yes ☐ No ☐	or neck	Yes ☐ No ☐
Cortisone Treatments	Yes ☐ No ☐	Nervous Problems	Yes ☐ No ☐	Ulcer	Yes ☐ No ☐
Cough, persistent or bloody	Yes ☐ No ☐	Pacemaker	Yes ☐ No ☐	Venereal Disease	Yes ☐ No ☐
Diabetes	Yes ☐ No ☐	Psychiatric Care	Yes ☐ No ☐	Weight Loss, unexplained	Yes ☐ No ☐
Emphysema	Yes ☐ No ☐	Radiation Treatment	Yes ☐ No ☐		

Do you wear contact lenses? Yes ☐ No ☐

Women:

Are you pregnant? Yes ☐ No ☐ Due date _____ Are you nursing? Yes ☐ No ☐

Taking birth control pills? Yes ☐ No ☐

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____

_____

Pharmacy Name _____

Phone (_____) _____

ALLERGIES

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other _____

☐ Latex _____

UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? Yes ☐ No ☐

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Has there been any change in your health since your last dental appointment? Yes ☐ No ☐

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Submit