HEALTH HISTORY

FIRST, MIDDLE AND LAST NAME_____ PREFERRED NAME_____

HAVE YOU BEEN UNDER THE CARE OF A MEDICAL DOCTOR IN THE LAST 2 YEARS? Y / N

IF YES, FOR WHAT_____

PHYSICIAN'S NAME AND PHONE_____

HAVE YOU BEEN ADMITTED TO THE HOSPITAL IN THE LAST 5 YEARS_____ Y / N

ARE YOU TAKING MEDICATIONS _____ Y / N

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS_____ Y / N

HAVE YOU TAKEN DIET MEDICATIONS Y / N FEN-PHEN, PONDIMEM, REDUX Y / N

HAVE YOU TAKEN OR TAKING NOW BISPHOSPHONATE MEDICATION FOR BONE LOSS? Y / N

ARE YOU TAKING BIRTH CONTROL Y / N PREGNANT OR NURSING Y / N

DO YOU USE TOBACCO Y / N DO YOU USE ALCOHOL Y / N

HAVE YOU BEEN DIAGNOSED WITH BREAST OR PROSTATE CANCER? Y / N

DO YOU OR HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS / FAMILY HISTORY Y / N

Heart (Surgery, Disease, Attack)	Y N F	Ulcers	Y N F	Hepatitis type A, B, C, other	Y N F
Chest Pain	Y N F	Diabetes	Y N F	Venereal Disease	Y N F
Congenital Heart Disease	Y N F	Thyroid Problems	Y N F	AIDS	Y N F
Heart Murmur	Y N F	Glaucoma	Y N F	HIV Positive	Y N F
High Blood Pressure	Y N F	Contact Lenses	Y N F	Osteoporosis	Y N F
Mitral Valve Prolapse	Y N F	Emphysema	Y N F	Blood Transfusion	Y N F
Artificial Heart Valve	Y N F	Chronic Cough	Y N F	Hemophilia	Y N F
Heart Pacemaker	Y N F	Tuberculosis	Y N F	Sickle cell Disease	Y N F
Rheumatic Fever	Y N F	Asthma	Y N F	Bruise Easily	Y N F
Arthritis/Rheumatism	Y N F	Hay Fever	Y N F	Liver Disease	Y N F
Cortisone Medication	Y N F	Latex Sensitivity	Y N F	Yellow Jaundice	Y N F
Swollen Ankles	Y N F	Allergies or Hives	Y N F	Neurological Disorders	Y N F
Stroke	Y N F	Sinus Trouble	Y N F	Epilepsy or Seizures	Y N F
Diet (Special/Restricted)	Y N F	Radiation Therapy	Y N F	Fainting or Dizzy Spells	Y N F
Artificial Joints (hip, knee, etc.)	Y N F	Chemotherapy	Y N F	Nervous/Anxious	Y N F
Kidney Trouble	Y N F	Tumors	Y N F	Psychological Care	Y N F

DO YOU HAVE ANY CONDITIONS THAT ARE NOT LISTED _____ Y / N

HAVE YOU HAD A SLEEP STUDY Y / N

DO YOU USE MORE THAN 2 PILLOWS WHEN YOU SLEEP Y / N

DO YOU OR A FAMILY MEMBER SNORE OR STOP BREATHING WHILE YOU SLEEP Y / N

BMI_____, HEIGHT_____, WEIGHT_____, LOSS OR GAIN OF 10 POUNDS OR MORE Y / N

I understand that above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should any further information be needed, you have my permission to ask the respective health care provider or agency; who may release such information to you. I will notify the doctor of change in my health or medication.

SIGNATURE _____ DATE _____