HEALTH / DENTAL HISTORY

We are a health-centered dental practice, thus we are concerned with your total well-being, not just your oral health. Please fill out the health questionnaire below completely - even if some of the questions may not seem relevant to your dental health. **All information is completely confidential.** (Circle yes or no)

1. Have you been under the care of a physician during the past two years? ..... **YES** **NO**

   If yes, for what? _____

   Physician's Name: _____ Phone:(_____) _____

   Address _____
   (Street) (City) (State) (Zip)

2. Are you taking medication, drugs or pills now? ..... **YES** **NO**

   If yes, please list name / dosage _____

3. Have you ever taken Fen-Phen or other dietary aids? ..... **YES** **NO**

4. Are you aware of having an allergic **(or adverse reaction)** to any medication? ..... **YES** **NO**

   If yes, please list _____

5. Have you had unfavorable reactions to any of the following? (Please circle)

   ASPIRIN CODEINE LOCAL ANESTHETICS SEDATIVES SULFA PENICILLIN

6. Were you ever required to take an antibiotic premedication for dental treatment due to any of the following medical conditions? (Please circle)

   HEART MURMUR ARTIFICIAL HEART VALVE MITRAL VALVE PROLAPSE
   RHEUMATIC FEVER ARTIFICIAL JOINT (hip, knee, etc.)

7. Indicate which of the following you have had, or have at present. (Circle yes or no)

Organ Transplant	**YES**	**NO**	Osteoporosis	**YES**	**NO**
Heart (Surgery, Disease, Attack)	**YES**	**NO**	Chronic Cough	**YES**	**NO**
Chest Pain	**YES**	**NO**	Tuberculosis	**YES**	**NO**
Congenital Heart Disease	**YES**	**NO**	Asthma	**YES**	**NO**
Heart Murmur	**YES**	**NO**	Allergies	**YES**	**NO**
High Blood Pressure	**YES**	**NO**	Radiation Treatments	**YES**	**NO**
Artificial Heart Valve	**YES**	**NO**	Malignancies / Cancer	**YES**	**NO**
Heart Pacemaker	**YES**	**NO**	Hepatitis A (infectious)	**YES**	**NO**
Rheumatic Fever	**YES**	**NO**	Hepatitis B (serum)	**YES**	**NO**
Arthritis / Rheumatism	**YES**	**NO**	Non-A Non-B Hepatitis	**YES**	**NO**
Stroke / Use of blood thinners	**YES**	**NO**	A.I.D.S	**YES**	**NO**
Artificial Joint (Hip, Knee, etc.)	**YES**	**NO**	HIV Positive	**YES**	**NO**
Kidney Trouble	**YES**	**NO**	Blood Transfusions	**YES**	**NO**
Ulcers	**YES**	**NO**	Anemia	**YES**	**NO**
Diabetes	**YES**	**NO**	Epilepsy / Seizures	**YES**	**NO**
Thyroid Problems	**YES**	**NO**	Fainting / Blackouts	**YES**	**NO**
Glaucoma	**YES**	**NO**	Nervous Disorders	**YES**	**NO**
Emphysema	**YES**	**NO**	Psychiatric / Psychological Care	**YES**	**NO**
			Alcohol / Drug Dependency	**YES**	**NO**
Female: Are you pregnant and/or nursing	**YES**	**NO**			