HEALTH HISTORY

Patient Name _____
First Name MI Last Name

Physician's Name_____ _____ City _____ Date of last Visit _____
First Name Last Name

Have you ever taken any of the group of drugs referred to as "Phen-Fen" ☐Yes ☐No
Have you ever taken any of the group of drugs referred to as "bisphosphonates"? ☐ Yes ☐No
(fosamax, actonel, aredia, zometa)
Have you been hospitalized or had a serious illness within the past 5 years? ☐Yes ☐No
Do you require premedication with antibiotics for any of the following reasons?
☐Artificial Joints ☐Heart ☐Rheumatic Fever ☐ Phen/Fen

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS? CHECK (YES) OR (NO)

Y/N	Y/N	Y/N
☐☐ AIDS/HIV	☐☐ Congenital Heart Condition	☐☐ Psychiatric Care
☐☐ Alzheimer's disease	☐☐ Diabetes (type_____)	☐☐ Radiation Treatment
☐☐ Anemia (type _____)	☐☐ Ear (Cochlear) Implant	☐☐ Respiratory/Breathing
☐☐ Arthritis, Rheumatism	☐☐ Emphysema	☐☐ Rheumatic Fever
☐☐ Artificial Heart Valve	☐☐ Epilepsy or Seizures	☐☐ Sinus Trouble
☐☐ Artificial Joints	☐☐ Glaucoma	☐☐ Steroid Treatment
☐☐ Asthma	☐☐ Heart Murmur	☐☐ Stroke
☐☐ Back / Neck Problems	☐☐ Heart Disease / Heart Surgery	☐☐TMJ Disorder
☐☐ Bleeding Abnormality	☐☐ Hepatitis (type_____)	☐☐Tuberculosis
☐☐ Blood Thinners	☐☐ High Blood Pressure	☐☐ Tumor or Growth
☐☐ Cancer	☐☐ Kidney Disease	☐☐ Ulcer
☐☐ Chemical Dependency	☐☐ Liver Disease	☐☐ Venereal Disease
☐☐ Chemotherapy	☐☐ Pacemaker	☐☐ Other _____

FEMALES ONLY: Are you Pregnant? ☐ Yes ☐ No Due Date_____
Are you Nursing? ☐ Yes ☐ No
Are you taking Birth Control Pills? ☐ Yes ☐ No

List any **MEDICATIONS** you are currently taking and correlating diagnosis:

_____
_____
_____
_____

ALLERGIES: ☐Aspirin or NSAIDs ☐ Local Anesthetic ☐Latex
☐ Penicillin (or other antibiotics) ☐ Codeine ☐Sulfa Drugs
☐ Iodine ☐ Other_____

I have answered above completely and accurately.
Signature (patient or parent/guardian) _____**Date**_____