HEALTH HISTORY

PATIENT NAME: ______________________________

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall diagnosis, treatment plan and possibility of being accepted for care.

MEDICAL CARE

1. Are you in good health? YES NO
2. Date of last physical examination ______________________________
3. Are you now under the care of a physician? YES NO
   If so, what is the condition being treated? ______________________________
4. Who is your physician? ______________________________
   Phone Number (______)__________________
5. May we contact your physician? (if necessary) YES NO
6. Have you ever had a serious illness or operation? YES NO
   If so, what illness or operation? ______________________________
7. Have you ever been hospitalized? YES NO
   If so, what was the problem? ______________________________
8. Are you taking any prescribed medication? YES NO
   If so, what? ______________________________
9. Are you taking any over the counter medication? YES NO
   If so, what? ______________________________
10. Have you ever been pre-medicated with antibiotics for your dental tretment? YES NO
11. Are you sensitive or allergic to any drugs? YES NO
    If so, what? ☐ Penicillin ☐ Erythromycin ☐ Codiene ☐ Other: ______________________________
12. Have you ever taken Fen-Phen Redux Pondimin YES NO
13. Do you use any form of tobacco? YES NO
    If so, what? ______________________________
14. (Women) Are you pregnant? YES NO
    If so, what is your expected due date? ______________________________
15. (Women) Are you nursing? YES NO
16. (Women) Do you take birth control pills? YES NO
17. Have you ever had a hip or knee replaced? ...or any other joint repalcement? YES NO
    If so, when? ______________________________
18. Have you ever had and pins, screws, plates placed? YES NO
    If so, when? ______________________________
19. Have you ever had a stent placed? YES NO
    If so, when and where? ______________________________
20. Do you have a pacemaker? YES NO
21. Do you have any disease, condition or problem not listed that you think we should know about? YES NO
    If so, what? ______________________________
22. What is your pharmacy's name? ______________________________
    Phone Number (______)__________________