



HEALTH INFORMATION

Have you ever had any of the following? Please check those that apply:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Problems/Disease |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis |
| _____ | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mental Healthcare | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Growths | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Recent Weight Loss | Women: |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Currently pregnant |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Nursing |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Trying to get pregnant |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Seizures | OTHER: |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Problems | _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Stomach Problems | _____ |
| <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stroke | |

- Have you ever taken Fen-phen or Redux? Yes No
- Do you or have you used controlled substances? Yes No
- Do you have a history of tobacco use? Yes No
- Do you use alcohol? Yes No Frequency _____

- Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain: _____

- Are you now under the care of a physician? Yes No
If yes, please explain: _____

- Name of Physician: _____ Phone: _____
- Please list all current medications that you are taking (prescription & non-prescription) _____

- Do you have any health problems not listed or any that need further clarification? Yes No
If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail. I understand that providing incorrect information can be dangerous to my health.

Signature of patient, parent or guardian Date: _____

REFERRAL INFORMATION

- Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative
- Dental Office Yellow Pages Newspaper School Work Other _____

Name of person or office referring you to our practice: _____