

Name _____

D.O.B. _____

Health History cont'

Have you been hospitalized? Yes No If yes, please explain. _____

Date of hospitalization(s) _____

Women: Are you Pregnant or trying to get pregnant Using oral contraceptive Nursing

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combination of Ionimin, Adipex, Fastin (brand name of phentermine), Pondimin (fenfluramine), and Redux (dexfenfluramine.) Y N

Do you use controlled substances? Yes No Are you currently taking any medications? Yes No

If yes, please list medications and doses _____

Name of pharmacy _____ Pharmacy phone number _____

Are you allergic to the following?

- Penicillin Local Anesthetic Sulfa Iodine Metal
- Aspirin Codeine Latex Acrylic Other

Please check the box to indicate if you had any of the following

- AIDS/HIV positive Cortisone treatments Hypoglycemia Shingles
- Anaphylaxis Congenital heart disease Irregular heartbeat Shortness of breath
- Anemia Cough, persistent or bloody Intestinal disease Sinus trouble
- Angina Diabetes Jaw pain Skin rash
- Arthritis, Rheumatism Emphysema Kidney disease Special diet
- Artificial heart valve Epilepsy or Seizures Leukemia Stroke
- Artificial joints Excessive bleeding Liver disease Swollen limbs
- Asthma Excessive thirst Low blood pressure Swollen glands
- Back problems Fainting or dizziness Lung disease Thyroid problems
- Abnormal bleeding Frequent diarrhea Mitral valve prolapse Tonsillitis
- Blood disease Frequent headaches Nervous problems Tuberculosis
- Blood transfusion Glaucoma Pacemaker Tumor or growth
- Breathing problems Hay fever Parathyroid disease Ulcer
- Bruise easily Hemophilia Psychiatric care Venereal disease
- Cancer Heart murmur Radiation treatment Unexplained weight
- Chemical dependency Heart problems Renal dialysis loss
- Chemotherapy Hepatitis type _____ Respiratory disease Other
- Chest pains Herpes Rheumatic fever
- Cold sores/fever blister High blood pressure Scarlet fever

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient or Guardian _____ Date _____

Signature of Doctor _____ Date _____

Privacy Practice Acknowledgement

(You may refuse this acknowledgement)

I, _____ have received a copy of the Notice of Privacy Practices.

(please print name)

I have been provided an opportunity to review it.

Signature

Date

For Office Use Only

Despite our attempts we were unable to obtain acknowledgement of Privacy Practices because:

____ Individual refuse to sign _____ Communication barriers prohibited us from obtaining acknowledgement

____ An emergency situation prevented us from obtaining acknowledgement

____ Other (please specify) _____