



## Health History

Physician's Name \_\_\_\_\_ Date of Last Visit / / Tel. No. ( )

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phenetermine), Pondimin (fenfluramine) and Reduc (dexfenfluramine) Yes  No

Please place a mark on "yes" or "no" to indicate if you have ever had or currently have any of the following:

AIDS/HIV	Yes <input type="checkbox"/> No <input type="checkbox"/>	Epilepsy	Yes <input type="checkbox"/> No <input type="checkbox"/>	Radiation Tx	Yes <input type="checkbox"/> No <input type="checkbox"/>
Anemia	Yes <input type="checkbox"/> No <input type="checkbox"/>	Fainting or Dizziness	Yes <input type="checkbox"/> No <input type="checkbox"/>	Respiratory Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Arthritis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Glaucoma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Rheumatic Fever	Yes <input type="checkbox"/> No <input type="checkbox"/>
Artificial Heart Valves	Yes <input type="checkbox"/> No <input type="checkbox"/>	Headaches	Yes <input type="checkbox"/> No <input type="checkbox"/>	Scarlet Fever	Yes <input type="checkbox"/> No <input type="checkbox"/>
Artificial Joints	Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Murmur	Yes <input type="checkbox"/> No <input type="checkbox"/>	Shortness of Breath	Yes <input type="checkbox"/> No <input type="checkbox"/>
Asthma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sinus Trouble	Yes <input type="checkbox"/> No <input type="checkbox"/>
Back Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hepatitis (Type _____)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Skin Rash	Yes <input type="checkbox"/> No <input type="checkbox"/>
Bleeding abnormally	Yes <input type="checkbox"/> No <input type="checkbox"/>	Herpes	Yes <input type="checkbox"/> No <input type="checkbox"/>	Special Diet	Yes <input type="checkbox"/> No <input type="checkbox"/>
Blood Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	High Bld. Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>	Stroke	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cancer	Yes <input type="checkbox"/> No <input type="checkbox"/>	Jaundice	Yes <input type="checkbox"/> No <input type="checkbox"/>	Swollen Feet or Ankle	Yes <input type="checkbox"/> No <input type="checkbox"/>
Chemical Dependency	Yes <input type="checkbox"/> No <input type="checkbox"/>	Jaw Pain	Yes <input type="checkbox"/> No <input type="checkbox"/>	Swollen Neck	Yes <input type="checkbox"/> No <input type="checkbox"/>
Chemotherapy	Yes <input type="checkbox"/> No <input type="checkbox"/>	Kidney Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Thyroid Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>
Circulatory Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Liver Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tonsillitis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Congenital Heart Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Low Bld. Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tuberculosis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cortisone Treatment	Yes <input type="checkbox"/> No <input type="checkbox"/>	Mitral Valve Prolapse	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tumors	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cough (Persistent)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Nervous Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Ulcer	Yes <input type="checkbox"/> No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>	Pacemaker	Yes <input type="checkbox"/> No <input type="checkbox"/>	Venereal Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Emphysema	Yes <input type="checkbox"/> No <input type="checkbox"/>	Psychiatric Care	Yes <input type="checkbox"/> No <input type="checkbox"/>	Weight Loss (unexplained)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you wear contact lenses?	Yes <input type="checkbox"/> No <input type="checkbox"/>				

### Women:

Are you pregnant? Yes  No  Due Date: / / Are you Nursing? Yes  No

Taking Birth Control Pills? Yes  No

## Medications

List any medications you are currently taking and the correlating diagnosis  
(Either Prescription or Over The Counter)

\_\_\_\_\_  
\_\_\_\_\_  
Pharmacy Name: \_\_\_\_\_  
Phone ( ) - \_\_\_\_\_

## Allergies

Aspirin  Local Anesthetic   
Sleeping Pills  Penicillin   
Codeine  Sulfa   
Iodine  Other: \_\_\_\_\_  
Latex  \_\_\_\_\_

## Medical Update

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? \_\_\_\_\_

Are you taking any new medications? \_\_\_\_\_ If so what? \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date: / / Witness Signature \_\_\_\_\_

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? \_\_\_\_\_

Are you taking any new medications? \_\_\_\_\_ If so what? \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date: / / Witness Signature \_\_\_\_\_