****HEALTH HISTORY**** **Patient's Name _____ Date _____**

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of lonimin, Adipex, Fastin (brand names of phentermine). Pondimin (fenfluramine) and Redux (dexfenfluramine).
□ yes or □ no

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax) or risedronate (Actonel) for osteoporosis or Paget's disease. □ yes □ no

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer. □ yes □ no
Date treatment began :_____

Have you ever had an orthopedic total joint (hip, knee, elbow finger) replacement. □ yes □ no date _____

Do you use controlled substances (drugs) □ yes □ no

Do you use tobacco (smoking, snuff, chew, bidis). □ yes □ no
If so, how interested are you in stopping *(circle one)* **VERY / SOMEWHAT / NOT INTERESTED**

Do you drink alcoholic beverages □ yes □ no ** if yes, how much in last 24 hours _____ typically in a week _____

Place a mark on "Y" (yes) or "N" (no) to indicate if you have had any of the following:

	Y	N		Y	N		Y	N
AIDS/HIV			Fainting or dizziness			Radiation		
Anemia			Glaucoma			Respiratory Disease		
Arthritis, Rheumatism			Headaches			Rheumatic Fever		
Artificial Heart Valve			Heart Murmur			Scarlet Fever		
Artificial Joints			Heart Problems			Shortness of Breath		
Asthma			Hepatitis Type _____			Sinus Trouble		
Back Problems			Herpes			Skin Rash		
Bleeding abnormally, with extractions or surgery			High Blood Pressure			Special Diet		
Blood Disease			Immune Deficiency			Stroke		
Cancer			Jaundice			Swollen Feet or Ankles		
Chemical Dependency			Jaw Pain			Swollen Neck Glands		
Chemotherapy			Kidney Disease			Thyroid Problems		
Circulatory Problems			Liver Disease			Tonsillitis		
Congenital Heart Lesions			Low Blood Pressure			Tuberculosis		
Cortisone Treatments			Mitral Valve Prolapse			Tumor or Growth on head or neck		
Cough, persistent or bloody			Multiple Sclerosis			Ulcer		
Diabetes			Nervous Problems			Venereal Disease		
Emphysema			Pacemaker			Weight Loss, unexplained		
Epilepsy			Psychiatric Care			Other :		

Have you ever been "premedicated" with antibiotics prior to receiving dental treatment, or informed that you should be premedicated? _____

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:_____
_____
_____
Physician Name _____
Phone (_____) _____
Pharmacy Name _____

ALLERGIES

□ Aspirin □ Local Anesthetic
□ Barbiturates □ Penicillin
□ Codeine □ Sulfa
□ Iodine □ Latex
□ Metals
□ Other _____
_____

Signature _____ date _____

****

UPDATES

Any changes in your health since your last dental appointment? _____
If so for what? _____ Any new medications?_____

Signature **date**

UPDATES *(to be filled in at future appointments)*

Have there been any changes in your health since your last dental appointment? ☐ yes ☐ no

For what condition?____

Are you taking any new medications?______ If so, what? ______________________________

Patient Signature ________________________________ Date ______________________

Doctor's Signature _______________________________ Date ______________________

UPDATES *(to be filled in at future appointments)*

Have there been any changes in your health since your last dental appointment? ☐ yes ☐ no

For what condition?____

Are you taking any new medications?______ If so, what? ______________________________

Patient Signature ________________________________ Date ______________________

Doctor's Signature _______________________________ Date ______________________

UPDATES *(to be filled in at future appointments)*

Have there been any changes in your health since your last dental appointment? ☐ yes ☐ no

For what condition?____

Are you taking any new medications?______ If so, what? ______________________________

Patient Signature ________________________________ Date ______________________

Doctor's Signature _______________________________ Date ______________________

UPDATES *(to be filled in at future appointments)*

Have there been any changes in your health since your last dental appointment? ☐ yes ☐ no

For what condition?____

Are you taking any new medications?______ If so, what? ______________________________

Patient Signature ________________________________ Date ______________________

Doctor's Signature _______________________________ Date ______________________

UPDATES *(to be filled in at future appointments)*

Have there been any changes in your health since your last dental appointment? ☐ yes ☐ no

For what condition?____

Are you taking any new medications?______ If so, what? ______________________________

Patient Signature ________________________________ Date ______________________