



HEALTH HISTORY

Are you in good physical health? Y N
 Date of last physical _____

Are you under the care of a Physician now? Y N
 If so, Name & Phone # _____

Is there anything your doctor says you should not do, take or eat? Y N
 If yes, please list and give reason _____

Have you ever been in hospital? Y N

Can you walk up a flight of stairs without stopping for breath? Y N

Are you taking any medications? Y N
 If so, please list and give reason? _____

Have you ever taken PHEN/PHEN or any weight reducing drug? Y N

Do you smoke? _____ How much? _____ Years _____ Y N

Are you sensitive or allergic to Latex, any drugs or antibiotics? Y N
 Please list _____

Women Only:

Could you be pregnant? Y N

Are you taking B. control pills? Y N

Please circle if you have had any of the following;

- | | | |
|---------------------------|--------------------|---------------------|
| Excessive bleeding | Artificial joint | Ulcers |
| Trouble healing | Migraine headaches | G.I. Disorder |
| Heart trouble | Heart pacemaker | HIV |
| Immune Disease(AIDS, ARC) | Heart attack | Lung disease |
| Heart murmur | Blood transfusion | Drug addiction |
| Stroke | Tuberculosis | Kidney disease |
| High/low blood pressure | Blood Disorder | Diabetes |
| Rheumatic fever | Seizures | Hepatitis |
| Tumor/Growth | Jaundice | Radiation Treatment |

Please add any other medical/health information:

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medicines change, I will inform the dental professional at the next appointment.

Signature _____ Date _____

Please Turn Page Over for Final Document & Bring Paperwork to your Appointment