HEALTH HISTORY

How Did You Hear About Us? ____

Name ______________________________DOB _____________ Date___________________

Home Address____

Home phone: ____________ Cell phone ______________Email _________________________

Physician's Name ________________________________ Date of last Physical _______________

Date of last health care exam ________What was this exam for? _________________________________

Have you been hospitalized in the last 5 years? ____yes ____no

If yes, reason: ____

Are you currently receiving care? ____yes ____no if yes, nature of care: ___________________________

Have you ever had any of the following?

	Yes	No		Yes	No
Heart Problems	___	___	Epilepsy	___	___
High Blood Pressure	___	___	Chronic Headaches	___	___
Low Blood Pressure	___	___	Hepatitis, Jaundice or Liver Disease	___	___
Circulatory Problems	___	___	Cancer	___	___
Nervous Problems	___	___	Special Diet	___	___
Swollen Neck Glands	___	___	Hemophilia	___	___
Rheumatic Fever	___	___	Sinus Problems	___	___
Psychiatric Care	___	___	Respiratory Disease	___	___
Radiation Treatment	___	___	Chronic Diarrhea	___	___
Artificial Heart Valves	___	___	Lyme Disease	___	___
or joints			Arthritis	___	___
Allergies to anesthetics	___	___	Stroke	___	___
Recent Weight Loss	___	___	Allergies to Medicines or Drugs	___	___
Ulcer	___	___	Back Problems	___	___
General Allergies	___	___	Venereal Disease	___	___
Diabetes	___	___	Blood Disease	___	___
Chemical Dependency	___	___	Heart Murmur	___	___
Thyroid	___	___	Mitral Valve Prolapse	___	___
Scarlet Fever	___	___	HIV/AIDS	___	___

Do you have, or is there a family history of Cardiovascular Disease (Heart Disease/Stroke)? _____
Diabetes?____ Respiratory Disease? ____ Periodontal (gum) Disease? ____
Did you have a blood transfusion prior to 1992? _____yes _____ no
Is there anything about your medical history that you would like us to be aware of?____________________

Have you ever responded adversely to medical or dental treatment? _________________________________

Please list any prescription and/or over the counter medications including daily aspirin you are taking at this time:

1. _______________ For what condition? _____________________________
2. _______________ For what condition? _____________________________
3. _______________ For what condition? _____________________________
4. _______________ For what condition? _____________________________

Please list any vitamins and herb supplements you are taking at this time:

1. __________________
2. __________________
3. __________________

Are you taking Tagamet? (Cimetidine) ____yes ____no If yes, how often? __________

Are you allergic or have you had a reaction to:

a. local anesthetics ……………………………………………………………………____ yes ____no
b. Penicillin or other antibiotics ………………………………………………………... ____yes ____no
c. Aspirin ……………………………………………………………………………….. ____yes ____ no
d. Codeine, valium or other sedatives ………………………………………………….. ____yes ____no
e. Latex………………………………………………………………………………….. ____yes ____no
f. Other ………………………………………………………………………………….. ____yes ____no

Do you have any food allergies? ____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" ____yes ____no
*These include combinations of Lonimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).

Women: Are you pregnant? ____ yes ____ no
If no, are you planning a pregnancy in the near future? ____ yes ____ no
Are you a nursing mother? ____ yes ____ no
Are you taking birth control pills? ____ yes ____ no
Abnormal Blood Pressure? ____ yes ____ no
If yes, what is it usually: S /D (please circle)

Are you a smoker? ____yes ____no
If so, how much do you smoke per day? __________________________
Do you chew tobacco? ____yes____no

Do you drink alcoholic beverages? If yes, how many do you drink? ________ per day ________ per week

Do you take illegal drugs including marijuana? Cocaine? Methamphetamines? If so what, and how often?
____

Are there any special dental considerations you would like to make us aware of? ________________________________

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

________________________________ ____________________________________ ____________________
Patient(print name) *Patient Signature* *Date*
(If patient is a minor, Parent or Guardian)

Tony Cruz-McLeod DMD________________ ____________________________________
Doctor(print name) *Doctor Signature* *Date*

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