Health History con't

Have you been hospitalized? □ **Yes** □ **No** If yes, please explain and date. _____

Are You: ☐***Pregnant*** ☐***Trying to get pregnant*** ☐***Using oral contraceptives*** ☐***Nursing*** ☐***N/A***

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) Redux (dexfenfluramine)** □ **Y** □ **N**

Have you ever taken **"bisphosphonates"** (oral or IV)? Bisphosphonates are commonly used to treat Osteoporosis.

These Include **Fosomax, Boniva, Actenol, etc.** □ **Yes** □ **No**

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 type _____	□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	□Tonsilitis
□Blood disease	□Frequent headaches	□Nervous problems	□Tuberculosis
□Blood transfusion	□Glaucoma	□Pacemaker	□Tumor or growth
□Breathing problems	□Hay fever	□Osteoporosis	□Ulcer
□Bruise easily	□Hemophilia	□Psychiatric care	□Venereal disease
□Cancer type _____	□Heart murmur	□Radiation treatment	□Unexplained
□Chemical dependency	□Heart problems	□Renal dialysis	weight loss
□Chemotherapy	□Hepatitis type _____	□Respiratory disease	□Other _____
□Chest pains	□Herpes type _____	□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.

Print Patient Name _____**Date**_____

Patient or Parent/Guardian Signature_____ **Date**_____

TREATING DOCTOR

Signature of Doctor _____ **Date**_____