Patient Health History Form

Date: ______________ **Name:** ____________________ ____ _________________________________ **Date of Birth:** _______________

First MI Last MO/DAY/YEAR

Medications: Are you or have you ever taken any bone altering drugs or any drugs to treat Osteoporosis? □ Yes □ No

Are you or have you ever taken any of the group of drugs collectively referred to as "fen-phen"? □ Yes □ No

(including Ionimin, Adipex, Fastin (brand name of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine))

Please list all medications you are taking and why:

Name of Medication	Medical Condition
________________________	________________________
________________________	________________________
________________________	________________________
________________________	________________________

Please mark 'yes' or 'no' to indicate if you have or have had any of the following:

Condition	Yes/No	Condition	Yes/No
AIDS/HIV	□ Yes □ No	Jaw Pain	□ Yes □ No
Anemia	□ Yes □ No	Kidney Disease	□ Yes □ No
Arthritis, Rheumatism	□ Yes □ No	Liver Disease	□ Yes □ No
Artificial Heart Valve	□ Yes □ No	Low Blood Pressure	□ Yes □ No
Artificial Joint	□ Yes □ No	Mitral Valve Prolapse	□ Yes □ No
Asthma	□ Yes □ No	Nervous Problems	□ Yes □ No
Back Problems	□ Yes □ No	Pacemaker	□ Yes □ No
Bleeding abnormally, with extractions or surgery	□ Yes □ No	Psychiatric Care	□ Yes □ No
		Radiation Treatment	□ Yes □ No
Blood Disease	□ Yes □ No	Respiratory Disease	□ Yes □ No
Cancer	□ Yes □ No	Rheumatic Fever	□ Yes □ No
Chemical Dependency	□ Yes □ No	Scarlet Fever	□ Yes □ No
Chemotherapy	□ Yes □ No	Shortness of Breath	□ Yes □ No
Circulatory Problems	□ Yes □ No	Sinus Trouble	□ Yes □ No
Congenital Heart Lesion	□ Yes □ No	Stroke	□ Yes □ No
Cortisone Treatment	□ Yes □ No	Swollen Feet or Ankles	□ Yes □ No
Cough, persistent/ bloody	□ Yes □ No	Swollen Neck Glands	□ Yes □ No
Diabetes	□ Yes □ No	Thyroid Problems	□ Yes □ No
Emphysema	□ Yes □ No	Tuberculosis	□ Yes □ No
Epilepsy	□ Yes □ No	Tumor or growth on Head or neck	□ Yes □ No
Fainting/Dizziness	□ Yes □ No		
Glaucoma	□ Yes □ No	Ulcer	□ Yes □ No
Heart Attack	□ Yes □ No	Weight Loss, unexplained	□ Yes □ No
Heart Murmur	□ Yes □ No	Other not listed: ____________________	
Heart Problems	□ Yes □ No	____________________	
Hepatitis Type ____	□ Yes □ No		
Herpes	□ Yes □ No	***Women only:***	
High Blood Pressure	□ Yes □ No	Taking birth control pills?	□ Yes □No
Jaundice	□ Yes □ No	***Are you pregnant?***	□ Yes □ No
		Date due: ____________	
		Are you nursing?	□ Yes □ No

Allergies—mark all that apply:

□ Aspirin □ Codeine □ Iodine
□ Latex □ Local Anesthetic
□ Penicillin □ Sulfa
□ Other:

<u>Health History Update including surgeries/hospitalizations</u>

Date: ______ Pt initials _______ RDH/DR _______
Change ____________________________________

Date: ______ Pt initials _______ RDH/DR _______
Change ____________________________________

Date: ______ Pt initials _______ RDH/DR _______
Change ____________________________________

Date: ______ Pt initials _______ RDH/DR _______
Change ____________________________________

Date: ______ Pt initials _______ RDH/DR _______
Change ____________________________________

Date: ______ Pt initials _______ RDH/DR _______
Change ____________________________________

PHYSICIAN Name & Phone #

____

EMERGENCY CONTACT Name & Phone #

____

HAVE YOU HAD ANY SURGERGIES OR HOSPITALIZATIONS? □ Yes □ No

The preceding information about my health and medications is correct to the best of my knowledge.

____ ____________________
Signature of Patient, Parent, Guardian or Personal Representative Date

____ ____________________
Print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

____ ____________________
Doctor's Signature Date