

Health History

Physician's Name _____ Date of last visit _____

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

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

- | | | | | | | | | |
|---|------------------------------|-----------------------------|-----------------------|------------------------------|-----------------------------|------------------------------------|------------------------------|-----------------------------|
| AIDS/HIV | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Radiation Treatment | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Fainting or dizziness | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Respiratory Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Arthritis, Rheumatism | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Artificial Heart Valves | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Artificial Joints | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Murmur | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Shortness of Breath | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sinus Trouble | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Back Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hepatitis Type _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Skin Rash | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bleeding abnormally, with
extractions or surgery | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Herpes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Special Diet | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blood Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Jaundice | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Swollen Feet or Ankles | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chemical Dependency | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Jaw Pain | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Swollen Neck Glands | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chemotherapy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Circulatory Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tonsillitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Congenital Heart Lesions | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cortisone Treatments | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tumor or growth on head
or neck | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cough, persistent or bloody | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Nervous Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ulcer | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Emphysema | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Weight Loss, unexplained | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Do you wear contact lenses? Yes No

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:

 Pharmacy Name _____
 Phone (____) _____

Allergies

- | | |
|--|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Local Anesthetic |
| <input type="checkbox"/> Barbiturates (Sleeping pills) | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Latex | _____ |

Updates (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? Yes No
 For what conditions? _____
 Are you taking any new medications? _____ If so, what? _____
 Patient's Signature _____ Date _____
 Doctor's Signature _____ Date _____

Has there been any change in your health since your last dental appointment? Yes No
 For what conditions? _____
 Are you taking any new medications? _____ If so, what? _____
 Patient's Signature _____ Date _____
 Doctor's Signature _____ Date _____