

# 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 | Respiratory Disease             | <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 | Rheumatic Fever                 | <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 | Scarlet 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 | Shortness of Breath             | <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 | Sinus Trouble                   | <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 | Skin Rash                       | <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 | Special Diet                    | <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 | Stroke                          | <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 | Swollen Feet or Ankles          | <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 Neck Glands             | <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 | Thyroid Problems                | <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 | Tonsillitis                     | <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 | Tuberculosis                    | <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 | Tumor or growth on head or neck | <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 | Ulcer                           | <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 | Venereal Disease                | <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 | Weight Loss, unexplained        | <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 |                                 |                              |                             |
|  |                              |                             | Radiation Treatment   | <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                         | _____                                     |

## Dental History

- |   |                                   |                              |                             |                                |                              |                             |
|---|-----------------------------------|------------------------------|-----------------------------|--------------------------------|------------------------------|-----------------------------|
| Reason for today's visit _____  | Chew on one side of mouth         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mouth breathing                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| _____   | Cigarette, pipe, or cigar smoking | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mouth pain, brushing           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Former Dentist _____  | Clicking or popping jaw           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Orthodontic treatment          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| City/State _____  | Dry mouth                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pain around ear                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Date of last dental visit _____   | Fingernail biting                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Periodontal treatment          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Date of last dental X-rays _____  | Food collection between the teeth | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sensitivity to cold            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Place a mark on "yes" or "no" to indicate if you have had any of the following: | Foreign objects                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sensitivity to heat            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|   | Grinding teeth                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sensitivity to sweets          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bad breath  | Gums swollen or tender            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sensitivity when biting        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bleeding gums   | Jaw pain or tiredness             | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sores or growths in your mouth | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blisters on lips or mouth   | Lip or cheek biting               | <input type="checkbox"/> Yes | <input type="checkbox"/> No | How often do you floss? _____  |                              |                             |
| Burning sensation on tongue   | Loose teeth or broken fillings    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | How often do you brush? _____  |                              |                             |

# Dental Registration and History