Health History

R. Beryl Hunter, DMD, MD, PC

Answer all questions by circling Yes (Y) or No (N)

1. Age_____ Weight _____ Height _____
2. Are you in good health?..... Y N
3. Has there been any change in your general health in the past year?..... Y N
4. Date of last physical exam: _____/_____/_____
5. Are you now under a physician's care for a particular problem?..... Y N
6. Have you ever had any serious illness, operations, or hospitalizations? If so, describe..... Y N

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7. DO YOU HAVE OR HAVE YOU EVER HAD:

- A. *Rheumatic Fever or Rheumatic Heart Disease?..... Y N
- B. *Congenital Heart Disease?..... Y N
- C. *Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)?..... Y N
- D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)?..... Y N
- E. Seizures, Convulsions, Epilepsy, Fainting, Dizziness, Psychiatric Treatment, or other Nervous Disorder?..... Y N
- F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion, or bruise easily?..... Y N
- G. Liver Disease (Jaundice, Hepatitis)?..... Y N
- H. Kidney Disease?..... Y N
- I. Diabetes?..... Y N
- J. Thyroid Disease (Goiter)?..... Y N
- K. Arthritis?..... Y N
- L. Stomach Ulcers or Colitis?..... Y N
- M. Glaucoma?..... Y N
- N. *Implants placed anywhere in your body (heart valve, joint replacements, etc.)?..... Y N
- O. Radiation (x-ray) treatment for cancer?..... Y N
- P. Clicking or popping of the jaw joint or pain near ears?..... Y N
- Q. Sinus or Nasal Problems?..... Y N
- R. Any disease, drug, or transplant operation that has depressed your immune system?.... Y N
- S. HIV, AIDS, or ARC?..... Y N

If you answered YES to any of the "*" conditions, please call prior to your appointment as premedication may be required.

8. ARE YOU USING ANY OF THE FOLLOWING

- A. Antibiotics?..... Y N
- B. Anticoagulants (blood thinners)?..... Y N
- C. Aspirin or drugs such as Motrin, Aleve, or Ibuprofen?..... Y N
- D. High blood pressure medications?..... Y N
- E. Steroids (Cortisone, etc.)?..... Y N
- F. Tranquilizers?..... Y N
- G. Insulin or oral anti-diabetic drugs?..... Y N
- H. Digitalis, Indernal, Nitroglycerin or other heart drug?..... Y N
- I. Any regular medication, pills or drugs, either over-the-counter or prescription? If YES, please list:..... Y N

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9. ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:

- A. Local Anesthesia (Novocain, Lidocaine, etc.)?.. Y N
- B. Penicillin or other antibiotics?..... Y N
- C. Sedatives or Barbiturates?..... Y N
- D. Aspirin or Ibuprofen?..... Y N
- E. Codeine or other pain killers?..... Y N
- F. Latex or Rubber Products?..... Y N
- G. Eggs or Soy?..... Y N
- H. Other Allergies or reactions? Please list:..... Y N

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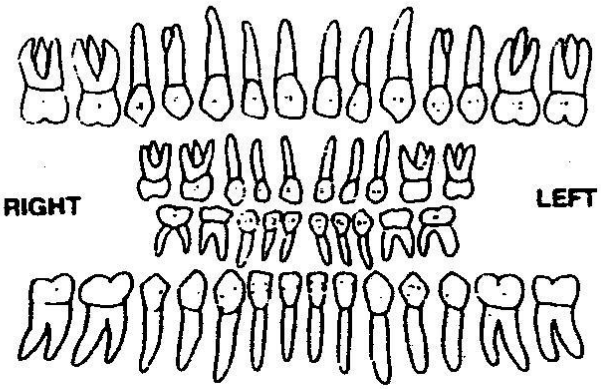
10. Do you smoke or chew tobacco?..... Y N
    How much per day:_____
11. Is there any past history of alcohol or chemical dependency or emotional disorder that may affect the care we provide you?..... Y N
12. Have you had any serious problems associated with any previous dental treatment?..... Y N
13. Have you or any immediate family member had any problems associated with intravenous anesthesia?..... Y N
14. Do you have any other disease, conditions, or problem not listed above that you think the doctor should know about?..... Y N
15. Do you wish to talk with the doctor privately about anything?..... Y N
16. Do you take or have you taken any medication for Osteoporosis?..... Y N

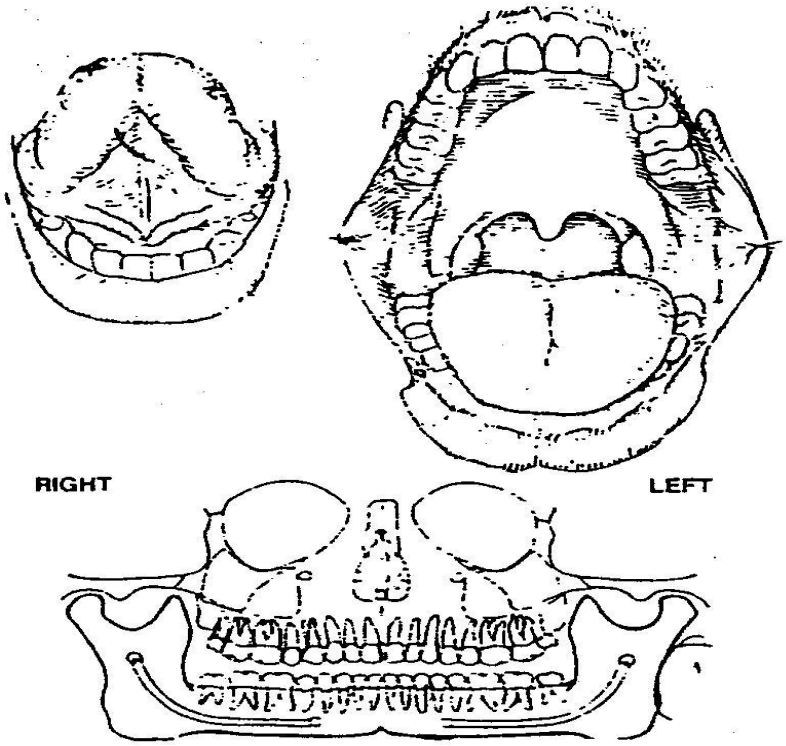
17. FEMALE PATIENTS ONLY:

- A. Are you pregnant, or is there any chance you might be pregnant?..... Y N
- *B. If you are using oral contraceptives, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.*

I understand the importance of a truthful health history to assist the doctor in providing the best care possible. I have had the opportunity to discuss my health history with my doctor. All responses will be kept confidential.

Patient Name | Signature of Person Competing Health History | Date | Doctor's Initials





CC:_____

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HPI:_____

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PMHx_____

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Allergies_____

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THIS SIDE FOR PHYSICIAN ONLY