DENTAL HISTORY

Reason for Today's visit_____Date of last dental care_____
Former Dentist_____Date of last dental x-rays_____
Address_____City_____State_____Zip_____

Please indicate if you have/had problems with any of the following:

___Bad Breath	___Grinding Teeth	___Sensitivity to hot
___Bleeding Gums	___Loose teeth or broken fillings	___Sensitivity to sweets
___Clicking or popping jaw	___Periodontal treatment	___Sensitivity when biting
___Food collection between teeth	___Sores or growths in mouth	___Sensitivity to cold

How often do you floss?_____How often do you brush?_____

MEDICAL HISTORY

Physician's Name_____Date of Last Visit_____

1. Have you ever taken any group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ____YES ____NO
2. Are you taking or have you ever taken Bisphosphonates (Fosamax, Boneva, Actonel, Aredia, Zometa) for osteoporosis, chemotherapy or multiple myeloma, etc? ____YES ____NO
3. Have you had any serious illnesses or operations? ____YES____NO Please describe_____
4. Have you ever had a blood transfusion? ____YES____NO If YES, give dates_____
5. (**WOMEN**) Are you pregnant or nursing?____YES____NO Taking birth control?____YES____NO
6. Please indicate if you have or had any of the following:

____Anemia	____Cortisone Treatments	____Hepatitis	____Scarlet Fever
____Arthritis, Rheumatism	____Cough, Persistent	____High Blood Pressure	____Short of Breath
____Artificial Joints	____Cough up Blood	____HIV/AIDS	____Skin Rash
____Asthma	____Diabetes	____Jaw Pain	____Stroke
____Back Problems	____Fainting	____Kidney Disease	____Swelling of Feet
____Blood Disease	____Glaucoma	____Mitral Valve Prolapse	____Tobacco Habit
____Cancer	____Headaches	____Pacemaker	____Tonsillitis
____Chemical Dependency	____Heart Murmur	____Radiation Treatment	____Tuberculosis
____Chemotherapy	____Heart Problems	____Respiratory Disease	____Ulcer
____Circulatory Problems	____Hemophilia	____Rheumatic Fever	___Venereal Disease

7. Are you taking any of the following?

____Antibiotics	____High Blood Pressure Medications	____Steroids(Cortisone,etc.)
____Anticoagulants (blood thinners)	____Tranquilizers	____Nitroglycerin, Digitalis,
____Aspirin drugs (Motrin/Aleve)	____Insulin or Oral Anti-Diabetic drugs	Inderal, other heart meds

8. Please list any other medication, vitamins, over the counter, or holistic remedies being taken:

_____

_____

9. Are you allergic to any drugs or other medications? ____YES ____NO If YES, please list:

_____

_____

I understand the importance of a truthful health history to assist the doctor in providing the best care possible. The above information is true and correct to the best of my knowledge.
X_____Date_____