DESERT FAMILY DENTAL

Patient______________________________________ **Birthdate**______________________ **Sex**_____

HEALTH HISTORY

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) and Redux (dexfenfluramine)? [ ] YES [ ] NO

Place a mark to indicate if you have, or have had in the past, any of the following:

___AIDS/HIV
___ANEMIA
___ARTHRITIS, RHEUMATISM
___ARTIFICIAL HEART VALVE
___ARTIFICIAL JOINTS
___ASTHMA
___BACK PROBLEMS
___BLEEDING ABNORMALLY, W/ SURGERY, EXTRACTIONS
___BLOOD DISEASE
___CANCER
___CHEMICAL DEPENDANCY
___CHEMOTHERAPY
___CIRCULATORY PROBLEMS
___CONGENITAL HEART LESIONS
___CORTISONE TREATMENTS
___COUGH, PERSISTENT
___DIABETES
___EMPHYSEMA
___EPILEPSY
___FAINTING OR DIZZINESS
___GLAUCOMA
___HEADACHES
___HEART MURMUR
___HEART PROBLEMS
___HEPATITIS TYPE ___
___HERPES
___HIGH BLOOD PRESSURE
___JAUNDICE
___JAW PAIN
___KIDNEY DISEASE
___LIVER DISEASE
___LOW BLOOD PRESSURE
___MITRAL VALVE PROLAPSE
___NERVOUS PROBLEMS
___PACEMAKER
___PSYCHIATRIC CARE
___RADIATION TREATMENT
___RESPIRATORY DISEASE
___RHEUMATIC FEVER
___SCARLET FEVER
___SHORTNESS OF BREATH
___SINUS TROUBLE
___SKIN RASH
___SPECIAL DIETARY NEEDS
___STROKE
___SWOLLEN FEET OR ANKLES
___SWOLLEN NECK GLANDS
___THYROID PROBLEMS
___TONSILLITIS
___TUBERCULOSIS
___TUMOR OR GROWTH ON HEAD OR NECK
___ULCER
___VENEREAL DISEASE

- Have you previously been diagnosed with sleep apnea? { } YES [ ] NO
- Do you wear contact lenses? { } YES [ ] NO

Women:

- Are you pregnant? [ ] YES [ ] NO Due Date? ________________
- Are you nursing? [ ] YES [ ] NO
- Are you taking birth control? [ ] YES [ ] NO

Medications:	Allergies:		
List any medications you are currently taking,	For your health and safety, please mark any		
and why you take it:	Known drug or material allergies:		
	___Aspirin	___Iodine	___Penicillin
	___Barbituates	___Latex	___Sulfa
Pharmacy Name	___Codeine	___Local Anesthetics	
Pharmacy Phone Number	Other (list):		

Physician's Name______________________________ Date of Last Medical Visit_______________

Previous hospitalizations, serious illnesses, or operations: _________________________________

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I understand that providing incorrect or incomplete information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in my medical status. To the best of my knowledge, I have provided DESERT FAMILY DENTAL with accurate and complete health and dental information. I authorize the dental staff to perform the necessary dental services I may need.

________________________________ ________________________________ ______________

Patient or Guardian Signature Printed Name Date