HEALTH HISTORY

Has there been any problem in your general health within the past 5 years?_____(Serious illness, hospitalization, surgery) If so, what was the problem?_____

The date of your last medical check-up:_____ Are you under a physician's care now?_____ If so, for what?_____

What tablet, pills, or liquids are you presently taking? (that includes aspirin, vitamins, tonics, etc.)_____

DO YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS:

Please circle which water you have. City or County water/Well water

Please check what medical conditions apply to you:

Rheumatic fever____
Rheumatic heart disease____
Heart attack____ If so, when_____
Congenital heart disease____
Mitral valve prolapse____
Heart murmur____
Pacemaker____
Taking blood thinner____
High blood pressure____
Heart By-Pass surgery in last 6 mos.____
Low blood pressure____
Chest pain____
Shortness of breath____
Swollen ankles____
Stroke____
Fainting Spells____
Seizures____
Blood disorders____
Anemia____
Leukemia____
Abnormal bleeding____
Prolonged healing____
Bruise easily____

Asthma____
Hay fever____
Breathing problems____
Hepatitis____
Jaundice____
Liver disease____
Kidney disease____
Kidney dialysis____
Kidney transplant____
Tuberculosis____
Lung disease____
Diabetes____
Blood transfusion____ If yes, when_____
Any indication, diagnosis, or treatment of Acquired immune deficiency syndrome (AIDS)?____
HIV positive____
Radiation treatment for a tumor or other growth____
Artificial prosthesis____ (joint replacement, heart valve, metal rods)
Women: Are you pregnant or breast feeding____

Do you have any disease, condition or problem not listed above that you think the doctor should know about?_____

Are you taking the drug fosomax? Circle YES or NO

Are you sensitive or allergic to: Penicillin____ Novacaine____ Aspirin____ Latex____ Anesthetics____ Other drugs:_____

_____I agree for Dr. Matt Smith or Dr. Page Manus to perform whatever dental services he or she feels is necessary after giving my consent.

_____ _____

Date

Patient Signature or
Parent or Guardian Signature