

# HEALTH HISTORY

Name \_\_\_\_\_ Date \_\_\_\_\_

Are you currently receiving care? No Yes      If yes, nature of care: \_\_\_\_\_

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Are you taking any of these medications?

Pre-medication before dental treatment?	No	Yes	Tagamet® (cimetidine) or Prilosec® (omeprazole)?	No	Yes
Antacids?	No	Yes	Cardizem® (diltiazem) or Calan, Isoptin® (Verapamil)?	No	Yes
Dilantin® or Tegretol®	No	Yes	Serzone® (nefazodone)	No	Yes
Barbiturates (any)	No	Yes	Diflucan® (fluconazole) or Sporonox® (itraconazole)	No	Yes
St. John's Wort or Kava-Kava?	No	Yes	Biaxin® (clarithromycin)	No	Yes
Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®)? If so, when did the treatment begin?			When did the treatment end?		
Have you ever taken any prescription drugs such as fen-phen for weight loss?				No	Yes
Do you consume grapefruit juice, grapefruits or grapefruit extract?				No	Yes

Please list any medications you are currently taking:

- |          |          |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |

Please list any dietary or herbal supplements you are taking, and for what purpose:

- |           |           |
|-----------|-----------|
| 7. _____  | 8. _____  |
| 9. _____  | 10. _____ |
| 11. _____ | 12. _____ |

Abnormal Blood Pressure? (Please circle)

No      Yes

Have you ever received a diagnosis of "high blood pressure"?

What is your normal blood pressure?      S      /D      Today: \_\_\_\_\_ / \_\_\_\_\_

Tobacco, Alcohol, Drugs

Do you use tobacco? If yes, circle type: smoke    chew    How much per day?	For how long?	No	Yes
Do you want to quit using tobacco?		No	Yes
Do you consume alcohol? If yes, approximately how many alcoholic beverages per week?		No	Yes
Do you use any mood altering drugs other than those previously listed?		No	Yes

Weight and Diet considerations

Weight	Meals per Day	Dietary Restrictions	Food Allergies
Sugar in your diet (circle one): <i>none</i> <i>slight</i> <i>moderate</i> <i>high</i>			