

# HEALTH HISTORY FORM

(please complete in ink)

Patient's Name: \_\_\_\_\_ How do you prefer to be addressed? \_\_\_\_\_

Answers to the following questions are for our records only and will be considered confidential.

1. Date of last Physical Examination \_\_\_\_\_ Physician's Name and phone number \_\_\_\_\_

2. Have you been under the care of a medical doctor during the past two years? Yes No

3. Have you been a patient in the hospital during the past two years? Yes No

4. Have you taken any medications in the last two years? If yes, which ones? Yes No

5. Have you ever taken the PhenFen Drug? Yes No

6. Are you allergic to (i.e. itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, any drugs, medications, metals, or latex? Yes No

If yes, explain: \_\_\_\_\_

7. Have you ever had any excessive bleeding requiring special treatment? Yes No

8. Circle any of the following which you have had or have at present:

Heart Failure	Kidney Trouble	Arthritis	Venereal Disease (Syphilis, Gonorrhea)
Heart Disease or Attack	Ulcers	Rheumatism	Cold Sores
Angina Pectoris	Mental Retardation	Cortisone Medicine	Herpes
High Blood Pressure	Emphysema	Glaucoma	Epilepsy or Seizures
Heart Murmur	Cough	Pain in Joints	Fainting or Dizzy Spells
Rheumatic Fever	Tuberculosis (TB)	Birth Defects	Nervousness
Congenital Heart Lesions	Asthma	HIV Positive, ARC, AIDS	Psychiatric Treatment
Scarlet Fever	Hay Fever	Hepatitis A (infectious)	Sickle Cell Disease
Artificial Heart Valve	Sinus Trouble	Hepatitis B (serum)	Bruise Easily
Heart Pacemaker	Allergies or Hives	Liver Disease	Use of Tobacco Products
Heart Surgery	Diabetes	Yellow Jaundice	Alcoholism/Drug Addiction
Artificial Joint	Thyroid Disease	Blood Transfusion	Chemotherapy/Radiation (Cancer, Leukemia)
Stroke	Anemia	Hemophilia	Sleep Apnea

9. Are you having any dental pain or discomfort at this time? Yes No

10. Are there now any growths or sores in or around your mouth? Yes No

11. Do you have any trouble chewing? Yes No

12. Does food catch between your teeth? Yes No

13. Do you habitually clench or grind your teeth during the day or night? Yes No

14. Do you have jaw and/or joint pain? Yes No

15. Do you Snore? Yes No Do you wake up tired? Yes No

16. Do you now have bleeding gums or any other gum problems? Yes No

17. WOMEN: Are you pregnant now: (Please inform us before x-rays are taken) Yes No

18. Is there anything that you dislike or would like to change about your smile? Yes No

19. Is there anything related to your medical or dental history that you have not indicated above? If yes, explain? \_\_\_\_\_ Yes No

I acknowledge that I am responsible for informing the doctor about any changes in my health history prior to treatment. I understand that my health history information will be used as necessary for diagnosis or treatment by Dr. Steven Pierce and/or Dr. Robert Pierce.

INITIAL DATE

**Complete for subsequent visits only: I have read my answers to the health history questions listed above and there are no changes.**

(1) \_\_\_\_\_ (2) \_\_\_\_\_ (3) \_\_\_\_\_ (4) \_\_\_\_\_ (5) \_\_\_\_\_  
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(6) \_\_\_\_\_ (7) \_\_\_\_\_ (8) \_\_\_\_\_ (9) \_\_\_\_\_ (10) \_\_\_\_\_  
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