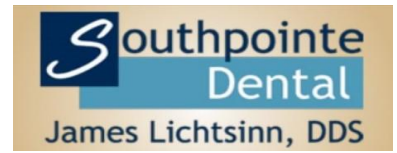


# CONFIDENTIAL HEALTH HISTORY



Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Are you being treated by a physician now? If YES, explain \_\_\_\_\_

Name of physician/Clinic: \_\_\_\_\_ Date of last medical examination \_\_\_\_\_

**DO YOU SMOKE OR USE TOBACCO PRODUCTS?** YES NO

**ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING?** (Select All That Apply)

- Aspirin Allergy     Antibiotics     Codeine Allergy     Latex Allergy  
 Penicillin Allergy     Local Anesthetic     Novocain     Food: \_\_\_\_\_

Other Allergies: \_\_\_\_\_

**MEDICAL CONDITIONS** - (Select All That Apply)

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Acid Reflux            | <input type="checkbox"/> Artificial Joints          | <input type="checkbox"/> Asthma                    |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Blood Disorder         | <input type="checkbox"/> Cancer / Tumor             | <input type="checkbox"/> Chemotherapy or Radiation |
| <input type="checkbox"/> Chemical Dependency    | <input type="checkbox"/> Cosmetic Surgery       | <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Digestive Problems        |
| <input type="checkbox"/> Damaged Heart Valve    | <input type="checkbox"/> Eating Disorder        | <input type="checkbox"/> Emphysema                  | <input type="checkbox"/> Headaches/Migraines       |
| <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> Heart Attack / Disease | <input type="checkbox"/> Hepatitis / Liver Disorder | <input type="checkbox"/> HIV+ / AIDS               |
| <input type="checkbox"/> Herpes                 | <input type="checkbox"/> Hay Fever              | <input type="checkbox"/> Kidney Disease/Trouble     | <input type="checkbox"/> Lung Disease              |
| <input type="checkbox"/> Low Blood Pressure     | <input type="checkbox"/> Osteoporosis           | <input type="checkbox"/> Persistent Cough           | <input type="checkbox"/> Pregnant or Nursing       |
| <input type="checkbox"/> Psychiatric Care       | <input type="checkbox"/> Pacemaker              | <input type="checkbox"/> Respiratory Problems       | <input type="checkbox"/> Skin Disease              |
| <input type="checkbox"/> Stroke                 | <input type="checkbox"/> Sinus Trouble          | <input type="checkbox"/> Sleep Apnea/CPAP           | <input type="checkbox"/> STD                       |
| <input type="checkbox"/> Seizures / Epilepsy    | <input type="checkbox"/> Tuberculosis (TB)      | <input type="checkbox"/> Surgery: _____             |  |
| <input type="checkbox"/> Other: _____           |   |   |  |

**ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS?** (Please circle)

Antibiotics    Aspirin    Coumadin    Blood Thinners    Birth Control: \_\_\_\_\_  
Recreational Drugs    Bisphosphonates: Fosamax, Actonel, Boniva, Reclast, Didronel, Zometa, Skelid

**MEDICATIONS AND PRESCRIPTIONS: Please list any supplements, prescriptions or recreational drugs:**

\_\_\_\_\_  
\_\_\_\_\_

**Is there any issue or condition that you would like to discuss with the dentist in private?** YES NO

To the best of my knowledge, I have answered every question completely and accurately. I will inform Dr Lichtsinn of any changes in my health and/or medications.

I authorize the Dr Lichtsinn to contact my physician if needed regarding concerns of my medical information. If Dr Lichtsinn should determine that there may be a potential medically compromised situation, medical consultation may be needed prior to dental treatment. I will not hold my Dr Lichtsinn or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

\_\_\_\_\_  
**Signature of patient (or guardian if minor)**

\_\_\_\_\_  
**Date**

**Relationship to Patient if Applicable:** \_\_\_\_\_