HEALTH HISTORY

Patient's Name:_____ Date:_____

Please mark an X to the right of YES or NO to answer the questions as they apply to you.

Your opinion of your health now is: EXCELLENT___ GOOD____ FAIR____ POOR____

1. YES___NO_____Have you ever had any illness, operations? Have you had any past hospital admissions?
   Please List: _____
2. YES___ NO__ Are you under a physician's care at present? If yes, for what problem(s)
3. YES___NO__ Are you taking any medications or drugs? If yes, please list:
4. YES__ NO___ Have you any history of drug abuse?

NAME AND PHONE NUMBER OF YOUR PHARMACY: _____(___)_____-_____

Are you allergic to any food or medicine: _____

5. YES___NO___ Penicillin YES____NO___ Aspirin YES ___NO___ Local Anesthesia YES____NO____ Iodine

Other-Please Specify:_____

Do you have, or had any of the following?

6.	YES	NO	Anemia	YES	NO	Diabetes
	YES	NO	Kidney Disease	YES	NO	Thyroid Disease
	YES	NO	Liver Disease	YES	NO	TB
	YES	NO	Hepatitis	YES	NO	Arthritis
	YES	NO	Epilepsy/Seizures	YES	NO	Venereal Disease
	YES	NO	Nervous Disease	YES	NO	Glaucoma
	YES	NO	Stomach Ulcers	YES	NO	Heart Disease
	YES	NO	Asthma/Emphysema	YES	NO	Hay Fever
	YES	NO	Cancer or Tumor	YES	NO	Aids/ARC, or positive HIV test

7. YES NO Do you have sinus problems?
8. YES NO Do your ankles swell?
9. YES NO Have you ever had Rheumatic Fever?
10. YES NO Do you have a heart murmur?
11. YES NO Do you have high blood pressure?
12. YES NO Have you had radiation treatment for a tumor, growth, or other condition?
13. YES NO Do you experience shortness of breath?
14. YES NO Do you bruise easily?
15. YES NO Do you bleed for a long time after scratching, cutting yourself, or after a dental extraction?
16. YES NO Does anyone in your family have a bleeding problem? If yes who?
17. YES NO Do you get sick after an injection?
18. YES NO Have you ever required a blood transfusion?
19. YES NO Do you have any hearing, visual problems, or other disabilities which we should consider in planning your dental treatment (e.g. glaucoma)?
20. YES NO Do you smoke? How often?
21. YES NO Do you drink? How often?

FOR WOMEN

22. YES NO Are you pregnant? If yes, how many months?
23. YES NO Do you have menstrual problems?
24. YES NO Are you taking birth control pills?
25. YES NO Have you reached menopause?

What treatment do you desire?

I hereby consent to examination and diagnostic test to enable Dr Anthony Farole to perform the necessary treatment for myself and/or my dependent to reestablish and maintain optimum oral health. I also give consent for necessary anesthetic agents.

PATIENT 'S SIGNATURE: _____