5 HEALTH HISTORY

Physician's Name________________ Date of last visit________________

Are you under medical treatment now? ☐ Yes ☐ No If so, please describe condition ________________

Have you been hospitalized or had any surgical operation, or had a serious illness within the last 5 years? Or are you scheduled for any procedure in the near future? Please explain________________

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Condition			Condition			Condition		
AIDS/HIV	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fainting or dizziness	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hepatitis Type______	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
			High Blood Pressure	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Swollen Feet or Ankles	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	Tumor or growth on head or neck	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No			
Diabetes	☐ Yes	☐ No	Pins, Plates, Stents, or Implants placed	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No				Venereal Disease	☐ Yes	☐ No
						Weight Loss, unexplained	☐ Yes	☐ No

Have you had eye surgery in the last 2 years ☐ Yes ☐ No

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due date ________ Are you nursing ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:
____
____

Pharmacy Name ________________

Phone (____) ________________

ALLERGIES

- ☐ Aspirin
- ☐ Barbiturates (Sleeping pills)
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Metals
- ☐ Penicillin or other Antibiotics
- ☐ Sedatives
- ☐ Sulfa Drugs
- ☐ Other________________

AUTHORIZATION AND RELEASE

I certify that I, and/or my dependents(s), have insurance coverage with ________________ (Name of Insurance Company (ies)) and assign directly to Dr. Scott Herman all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Herman may use my health care information and may disclose such information to the above named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

For the purpose of advancing medical-dental education, I give permission for Dr. Scott Herman to make and use any records including x-rays, dental casts, and photographs of me/the patient for diagnostic, educational, endorsement, or research purposes.

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Signed: ________________ Date: ________ Relationship to patient: ________
(Signature of Patient, Parent Guardian or Personal Representative)

6 UPDATES (To be filled in at future appointments)

Date ________ Blood Pressure ________ Pulse ________
Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No
For what conditions? ________________
____
Are you taking any new medications? ________
If so, what? ________________
____
Patients Initials ______ Doctor's Initials ______ Staff Initials ______

Date ________ Blood Pressure ________ Pulse ________
Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No
For what conditions? ________________
____
Are you taking any new medications? ________
If so, what? ________________
____
Patients Initials ______ Doctor's Initials ______ Staff Initials ______