11. Are you or have you taken any diet drugs such as Phen-Fen, Redux, or Pondimin? ..... Yes No
12. Have you had surgery, x-ray or drug treatment for a tumor, growth, or other condition of the head or neck?.... Yes No
13. Are you taking any drugs or medicine; vitamins, over the counter or prescribed? ..... Yes No
    If so, what? _____
14. Are you taking any of the following? ..... Yes No
    a. Antibiotics or sulfa drugs? ..... Yes No
    b. Anticoagulants (blood thinners)? ..... Yes No
    c. Medicine for high blood pressure? ..... Yes No
    d. Cortisone (steroids)? ..... Yes No
    e. Tranquilizers? ..... Yes No
    f. Antihistamines? ..... Yes No
    g. Aspirin? ..... Yes No
    h. Insulin, tolbutamide (Orinase) or similar drug? ..... Yes No
    i. Digitalis or drugs for heart trouble? ..... Yes No
    j. Nitroglycerin? ..... Yes No
    k. Oral contraceptive or other hormonal therapy? ..... Yes No
    l. Other _____
15. Are you allergic or have reacted adversely to:

a. Local anesthetics?	Yes	No	Codeine or other narcotics?	Yes	No
b. Penicillin or other antibiotics?	Yes	No	Hay Fever?	Yes	No
c. Sulfa drugs?	Yes	No	Animals?	Yes	No
d. Barbiturates, sedatives, or sleeping pills?	Yes	No	Food?	Yes	No
e. Aspirin?	Yes	No	Metals?	Yes	No
f. Iodine?	Yes	No	Latex?	Yes	No

    g. Other (specify) _____
16. Have you had any serious trouble associated with any previous dental treatment? ..... Yes No
    If so, explain _____
    _____
17. Do you have any disease, condition, or problem not listed above that you think I should know about? ..... Yes No
    If so, explain _____
    _____
18. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation? ..... Yes No
19. Are you wearing contact lenses? ..... Yes No
20. Women only. Are you or could you be pregnant? ..... Yes No
21. Are you wearing removable dental appliances? ..... Yes No

Note: **Both Doctor and patient are encouraged to discuss any and all relevent patient health issues prior to treatment.**
I understand that I am responsible for the difference between my treatment cost and the amount my dental insurance covers.

_____

Signature of Patient / Legal Guardian **Date**

Health History Update: On a regular basis the patient should be questioned about any medical history changes, date and comments notated, along with signature.

Date	Signature of Patient	Signature of Doctor	Date
___/___/___	_____	_____	___/___/___
___/___/___	_____	_____	___/___/___
___/___/___	_____	_____	___/___/___
___/___/___	_____	_____	___/___/___
___/___/___	_____	_____	___/___/___
___/___/___	_____	_____	___/___/___
___/___/___	_____	_____	___/___/___