HEALTH HISTORY FORM

Dental Arts Building
Andrew Rastegar DDS

Name_____
Address _____City_____
State_____ Zip_____Sex (M/F)_____Marital Status_____
Birth Date_____SS# _____ Drivers License# _____
Home Phone _____Mobile Phone _____
Emergency Contact_____Contacts # _____
Responsible Party _____Billing Address _____
Insurance (Y/N)_____Employer Name _____ Group#_____
Insurance Company Name_____ID# _____
Please tell us who referred you to our office? _____

Please Answer the Following Questions

	YES	NO
1. Have you been hospitalized within the last two years?	____	____
2. Have you been under the care of a medical doctor within the past two years?	____	____

Physician's Name_____ Phone Number_____

3. Are you **ALLERGIC** to any medications?	____	____
Please list_____		
4. Have you ever had a **Heart Attack**?	____	____
5. Have you had a **Heart Valve** replaced?	____	____
6. Have you ever had **Rheumatic Fever**?	____	____
7. Do you have an **Artificial Joint**, such as a hip or knee?	____	____
8. Have you ever had **excessive bleeding** requiring special treatment?	____	____
9. Have you ever been treated for **osteoporosis**?	____	____
10. Have you ever been prescribed **Fosamax**, **Zometa** or other **Bisphosphonates**?	____	____
11. Do you require more than two pillows when you sleep?	____	____
12. When you walk or climb stairs do you ever have pain in your chest?	____	____
13. Do your ankles swell during the day?	____	____
14. Are you on a special diet?	____	____
15. Have you lost or gained more than ten pounds during the past year?	____	____
16. Are you in a High Risk Group for HIV infection?	____	____
17. Have you tested positive on an HIV test?	____	____
18. Have you ever had a blood transfusion? (Year_____)	____	____
19. Has a doctor ever told you that you had a growth or tumor?	____	____
20. Have you ever had **Hepatitis**?	____	____
21. Do you have a **Pacemaker**?	____	____
22. Have you ever had a **Stroke** or **TIA**? (If so, when?_____)	____	____

(OVER)----------→

	YES	NO
23. Do you have **High Blood Pressure**?	____	____
24. Do you have **Diabetes**?	____	____
25. Do you have **Lupus Erythematosus**?	____	____
26. Are you being treated by Dialysis?	____	____

27. Please list all medications you are currently taking:_____

_____

_____

28. **WOMEN: ARE YOU PREGNANT?**	____	____
29. Have you any health condition not listed above? (Condition:_____)	____	____
30. Are you presently, or have you been, addicted to any substance?	____	____
31. Have you ever smoked/used tobacco products?	____	____

How many years?____ How many packs per day?_____

32. Do you consider yourself to be healthy at this time??.	____	___

Please circle any of the following conditions which apply to your medical history:

Heart Disease	Lung Disease	Yellow Jaundice	Fainting or Dizzy Spells
Congenital Heart Lesion	Tuberculosis	Cancer/Leukemia	Radiation Therapy
Heart Surgery	Asthma	Anemia	Epilepsy/ Seizure Disorder
Angina Pectoris	Hay Fever	Hemophilia	Allergies or Hives
Glaucoma	Sinus Infection	Sickle Cell Disease	Ulcers
Pain in Jaw Joints	Arthritis	Thyroid Disease	Venereal Disease
Cold Sores	Scarlet Fever	Use Cortisone Medications	SMOKER

To the best of my knowledge all of the preceding information is true and accurate. Should there be any change in my health, or in the medications I may be taking, I will inform the dentist at my next appointment.

Date_____ Signature of Patient or Guardian_____

What is your chief Oral Complaint/Concern?_____

---------- Below For Office Use ONLY ----------

Medical History Update

Date Signature

_____

_____

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