HEALTH HISTORY

Please complete the following confidential information. Your complete answers will assist us in treating you with consideration for your special needs.

Family Physician_____Date of last visit_____Reason for this visit_____

1. Do you have a current medical problem or condition? Condition: _____ □ YES □ NO
   If yes, physician's name:_____Phone: _____

2. Have you been hospitalized or have you had a serious illness within the last 5 years? □ YES □ NO
   If so, list illness or operations/dates:_____
   _____

3. Do you have heart trouble or any form of cardiovascular disease (Please (√) check known conditions)? □ YES □ NO

□ Heart surgery (Date_____)	□ Angina/chest pains (Frequency _____)	□ High blood pressure
□ Prosthetic heart valve (Date_____)	□ Heart attack (Date_____)	□ Stroke (Date_____)
□ Bypass (Date_____)	□ Heart murmur	□ Low blood pressure
□ Angioplasty (Date_____)	□ Mitral valve defect	□ Atherosclerosis
□ Pacemaker (Date _____)	□ Congenital heart defect	□ Other _____

4. Please list <u>any</u> medications and dosages you currently take or have taken in the last year: _____
   _____
   _____

5. Are you under any unusual stress at home or at work? If yes, explain: _____

6. Do you or have you ever had any of the following (please (√) check all known conditions)? □ YES □ NO

□ Tuberculosis (Date_____)	□ Epilepsy or seizures	□ Hepatitis (Date_____Type_____)
□ Liver disease or jaundice	□ Persistent cough	□ Fainting or dizzy spells
□ Kidney disease	□ Emphysema/Asthma	□ Arthritis
□ Diabetes	□ Sinus trouble/Hay fever	□ Chronic head, neck or back pain
□ Hypo/Hyperglycemia	□ Allergies or hives _____	□ Artificial joint, limb, or implant (hip, knee)
□ Glaucoma	□ HIV	□ Nervousness
□ Hypo/Hyperthyroidism	□ AIDS or ARC	□ Psychiatric treatment
□ Stomach or intestinal ulcers	□ Herpes	□ Alcoholism
□ Prolonged bleeding	□ Drug Addiction	□ Venereal Disease (Syphillis, Gonorrhea)
□ Anemia	□ Cancer _____	□ Special diet
□ Sickle cell disease	□ Chemotherapy (Date _____)	□ Cosmetic Surgery (face, neck)
□ Blood transfusion	□ Cortisone medicine	□ Wearing contact lenses
□ Bruise easily	□ Limitation of activity	□ Other _____

□ Smoking history: since age:_____Packs/day:_____

7. Have you ever taken prophylactic antibiotics prior to dental treatment? □ YES □ NO

8. Are you allergic to or have you had any unusual reaction to any drugs or medicines? □ YES □ NO
   If yes, please list:_____

9. Are you allergic to or have you ever reacted adversely to latex? □ YES □ NO

10. Have you had surgery, radiation or other treatments for a tumor or growth to head or neck? □ YES □ NO

11. For women only: Are you pregnant? If so what month?_____ □ YES □ NO
    Are you taking birth control pills? □ YES □ NO

I understand the responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time of service. The above medical information is correct to the best of my knowledge. If I have any change in my health or medications, I will inform the doctor at my next appointment. I hereby authorize the release of any medical information to an insurance company I claim benefits with and assign those benefits to Thomas H. Pitts, D.M.D. In addition, I hereby grant permission for the release of any medical information to any physician, if deemed necessary for my dental care. I authorize the taking of radiographs, photographs, or other diagnostic measures appropriate for a thorough evaluation, and give consent for dental treatment to be preformed by Dr. Pitts and his staff. I understand the use of anesthetic agents embodies a certain risk.

Patient Signature _____Date_____
Parent/Financially Responsible Person _____Relationship_____