Rosenwald & Associates
Cosmetic, Restorative and Preventive Dentistry

HEALTH HISTORY FOR: _____

Yes *No* **Are you currently under a physician's care? If so, why?** _____

_____

Physician's name: _____ Phone: _____ Date of last physical: _____

Yes *No* **Are you taking any medications or health related substances?**
If so, please list what you take and why.

Medication _____ For _____
Medication _____ For _____
Medication _____ For _____
Medication _____ For _____
Medication _____ For _____
Medication _____ For _____
Medication _____ For _____
Medication _____ For _____
Medication _____ For _____
Medication _____ For _____

Yes *No* **Are you allergic to any medications, latex, or other substances? If so, what?** _____

_____

Do you have or have you ever had:

Yes *No* Asthma or other respiratory difficulties
Yes *No* Rheumatic fever
Yes *No* Heart murmurs
Yes *No* High blood pressure
Yes *No* Pacemaker or artificial heart valves
Yes *No* Other heart disease
Yes *No* Blood disorders, anemia, leukemia
Yes *No* Do you bleed excessively
Yes *No* Radiation treatment to your head or neck
Yes *No* Arthritis or rheumatism
Yes *No* Artificial joints, implants, or prosthesis
Yes *No* Stomach problems
Yes *No* Kidney or liver problems
Yes *No* Diabetes
Yes *No* Epilepsy or seizure disorders
Yes *No* Positive HIV test or AIDS
Yes *No* Hepatitis
Yes *No* Tuberculosis
Yes *No* Drug or alcohol addiction
Yes *No* Psychiatric treatment

Yes *No* Do you smoke or use any other forms of tobacco? _____
If so, what and how often?

Yes *No* Have you taken oral Bisphosphonate drugs such as but not limited to: Actonel, Boniva, Didronel, Fosamax, Fosamax Plus D, Skelid?

Yes *No* Have you taken IV Bishposphonate drugs such as but not limited to: Aredia, Zometa?

Women:

Yes *No* Are you pregnant?
Yes *No* Do you use birth control medication?
Yes *No* If so, have you been counseled about possible antibiotic interactions?

Is there anything else we should know about your health? If so, please explain: _____

_____

_____

Signature _____ Date _____

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