Dean Brewer DDS, Amanda Brewer DDS

Confidential Health History

Patient Name ________________________________Date________________
Birthdate______________________________ Physician's Name ______________________________
Date of last Health care exam:____________________What was the exam for?_______________
Surgeries: (Please list type and date of surgery): ____

Weight _______________ Height_________________

1. Yes	No	Are you generally in good health?
2. Yes	No	Has there been a change in your health within the last year?
3. Yes	No	Have you been hospitalized or had a serious illness in the last year?
		If yes, explain____
4. Yes	No	Are you being treated by a physician now? For what________________________________
5. Yes	No	Have you had any problems with prior dental treatment? ___________________________
6. Yes	No	Are you in pain now? Chief complaint ____
7. Yes	No	Do you know what your blood pressure is now? Write here if known____/____

HAVE YOU EXPERIENCED:					
8. Yes	No	Bleeding problems, bruising problems	19. Yes	No	Frequent vomiting, nausea
9. Yes	No	Blurred Vision	20. Yes	No	Headaches
10. Yes	No	Chest Pain (angina)	21. Yes	No	Jaundice
11. Yes	No	Diarrhea, constipation, blood in stools	22. Yes	No	Joint pain, stiffness
12. Yes	No	Difficulty swallowing	23. Yes	No	Persistent cough, coughing up blood
13. Yes	No	Difficulty urinating, blood in urine	24. Yes	No	Recent weight loss, fever, night sweats
14. Yes	No	Dizziness	25. Yes	No	Ringing in ears
15. Yes	No	Dry Mouth	26. Yes	No	Seizures or Epilepsy
16. Yes	No	Excessive thirst	27. Yes	No	Shortness of breath (asthma) or COPD
17. Yes	No	Fainting spells	28. Yes	No	Sinus problems
18. Yes	No	Frequent urination	29. Yes	No	Swollen Ankles

DO YOU HAVE OR HAVE YOU HAD:					
30. Yes	No	AIDS or ARC HIV	56. Yes	No	Liver Disease
31. Yes	No	Anemia	57.Yes	No	Lymph Nodes-sore or enlarged
32. Yes	No	Arthritis, rheumatism	58. Yes	No	Nervous disorders
33. Yes	No	Blood Disorders	59. Yes	No	Pacemaker
34. Yes	No	Bacterial Endocarditis Previous	60. Yes	No	Psychiatric care
35. Yes	No	Blood transfusions	61. Yes	No	Scarlet Fever
36. Yes	No	Cancer, Tumor	62. Yes	No	Sickle Cell Disease
37. Yes	No	Chemotherapy or Radiation	63. Yes	No	Skin disease
38. Yes	No	Cold Sores	64. Yes	No	Slow Healing Mouth sores
39. Yes	No	Diabetes	65. Yes	No	Stomach problems, ulcers
40. Yes	No	Emphysema or respiratory/Lung Illness/TB	66. Yes	No	Surgeries
41. Yes	No	Eye disease	67. Yes	No	Thyroid disease
42. Yes	No	Family history diabetes, heart problems	68. Yes	No	Unintentional Weight gain or loss
43. Yes	No	Glaucoma	69. Yes	No	Allergies Please list below:
44. Yes	No	Hayfever			
45. Yes	No	Heart attack, heart defects,Angina,Surgery			
46. Yes	No	Heart Disease, congenital malformatin	70. Yes	No	Recreational drugs Please list below:
47. Yes	No	Heart Stent When Placed______			
48. Yes	No	Heart Valve(artificial or transplant)			
49. Yes	No	Hepatitis, other liver disease	71.Yes	No	Tobacco in any form
50. Yes	No	High blood pressure	72.Yes	No	Do you want to quit using tobacco?
51. Yes	No	Hospitalization			
52. Yes	No	Hyperthrophic Cardiomyopathy			
53. Yes	No	Kidney Disease, Dialysis			
54. Yes	No	Other Conditions:____			
55. Yes	No	Do you have or have you had any other disease or medical problem **NOT** listed on this form?			
		If so, please explain____	***OVER***		

73.Yes	No	Are you using any mood altering drugs other than previously listed?
74.Yes	No	Do you consume alcohol? If yes, approximatley how many alcoholic beverages per week
75.Yes	No	Have you been treated with Biophosphonate drugs (Fosamax, Aredia, Zometa, Actonel, Boniva
		Reclast or Prolia? If so,when did the treatment begin?______________When did it end?______

Medications: Please include all names, dosages and frequency taken:

1. ___________________________________ 4. ___________________________________
2. ___________________________________ 5. ___________________________________
3. ___________________________________ 6. ___________________________________

Please list any dietary, vitamins or herbal supplements you are taking, and for what purpose

1. ___________________________________ 3. ___________________________________
2. ___________________________________ 4. ___________________________________

FOR WOMEN ONLY:		
Yes	No	Are you or could you be pregnant? If no, are you planning a pregancy in the near future?
Yes	No	Are you a nursing mother?
Yes	No	Are you taking birth control pills?

Special Limitations____

Have you had reactions to anesthetics_______________________________

____

To the best of my knowledge, I/we have answered completely and accurately. I/we will inform my dentist of any changes in my health and/or medications

Patient or Parent Signature____**Date**_______________

DOCTOR'S USE ONLY

Comments on patient interview concerning medical history:

____

____

Significant Findings from questionaire or oral interview:

____

____

Dental Management considerations:

____

Consent : The undersigned hereby authorizes the Doctor to take X-rays, models, photographs, or any other diagnostic aid deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I/we also authorize the Doctor to perform any and all forms of treatment and therapy, and to prescribe medication that may be indicated in connection with)__________________________________ and further authorize and

(Patients Name)

consent that the Doctor choose and emply such assistance as deemed necessary.I/we understand the use of anesthetic agents embodies a certain risk.

Patients Signature ____ **Date**______________________

Responsible person if patient is a minor____

MEDICAL HISTORY REVIEWED BY _________________________________ **Date** _______________