YES NO 8. Are you *allergic* to, or have you ever had a reaction to any drug (such as penicillin, novocaine, sedatives, pain medications, aspirin, tylenol, nickel, iodine, etc.) if yes, please list:

____

____

9. Are you taking or have you taken any of the following medications?

YES NO antibiotics		YES NO tranquilizer
YES NO blood thinners		YES NO nitroglycerin
YES NO blood pressure medication		YES NO aspirin (daily or regularly)
YES NO cortisone, steroids		YES NO insulin
YES NO antihistamines, allergy drugs		YES NO thyroid medicine
YES NO hormones/oral contraceptives		YES NO digitalis

10. Please list the name and dosage of any drugs (prescription and over-the-counter) that you are taking. Please include any cortisone or steroids taken in the past two years

a.) ____________________ f.) ____________________

b.) ____________________ g.) ____________________

c.) ____________________ h.) ____________________

d.) ____________________ i.) ____________________

e.) ____________________ j.) ____________________

11. Do you use alcohol? If so, ______ drinks per day.

Do you use tobacco in any form? Yes ______ No______ For how many years? __________________

12. Does dental treatment make you nervous? No_______ Slightly______ Moderately______ Extremely______

*Recreational drugs such as cocaine, marijuana, stimulants or depressants may have serious/fatal interactions with local anesthetics or other common dental medications. Please describe the use of any drugs or discuss with doctor in complete confidentiality.*______________________________

13. Is there any disease, condition, or problem not listed that you think we should know about? If so, please explain: ____

____

NOTE: A CHANGE IN YOUR HEALTH STATUS SHOULD BE REPORTED TO THE OFFICE AT THE EARLIEST POSSIBLE TIME

To the best of my knowledge the information provided is correct. I understand that it is my responsibility to inform my dentist if I, or my minor child, has any change in health or medicines.

Patient Signature ____

Permission to release health information: I grant the right to the dentist to release health information obtained fro and information about my dental treatment to third party payors and/or health practitioners

Patient signature ____

Health History

Patient Name:______________________________ Date of Birth: __________ Today's Date: ________

THE FOLLOWING INFORMATION IS ESSENTIAL FOR DR. HOUSTON TO PROVIDE YOU WITH SAFE AND EFFECTIVE DENTAL CARE. YOUR ANSWERS ARE FOR OUR RECORDS ONLY AND WILL BE CONSIDERED CONFIDENTIAL. INCORRECT INFORMATION COULD BE ENDANGERING YOUR HEALTH.

If you are uncertain about any of the following, please discuss them with the dentist

YES NO 1. Are you in good health?

YES NO 2. Are you under the care of a physician?

Date of last medical exam ________________ Your physicians name ____________________________

Address ____ Phone ________________

YES NO 3. Have you ever been hospitalized or had a serious illness?

Explain: ____

____

YES NO 4. WOMEN – Are you pregnant or nursing?

YES NO 5. Do you take longer to heal now than previously (cuts, colds, etc.)?

YES NO 6. Do you now or have you ever used Fosamax, Boniva, or any bisphosphonate drug?

7. Do you have or have you ever had any of the following?

YES NO weakness, tire easily
YES NO noticeable weight change
YES NO night sweats
YES NO arthritis
YES NO skin rashes, hives
YES NO glaucoma
YES NO sinus problems
YES NO sore or hoarse throat
YES NO stroke
YES NO severe headache
YES NO convulsions, epilepsy, seizures
YES NO numbness, tingling
YES NO dizziness, fainting
YES NO artificial joints
YES NO tuberculosis
YES NO asthma, hay fever
YES NO stomach ulcers
YES NO bruise easily
YES NO thyroid condition, goiter
YES NO venereal disease
YES NO excess bleeding from a wound
YES NO swollen glands or lymph nodes

YES NO persistent cough
YES NO difficulty breathing lying down
YES NO diabetes
YES NO family history of diabetes
YES NO respiratory disease, COPD
YES NO rheumatic fever or scarlet fever
YES NO heart murmur, mitral valve prolapse
YES NO chest pain/discomfort
YES NO heart attack
YES NO shortness of breath
YES NO swelling of ankles
YES NO high or low blood pressure
YES NO artificial heart valve
YES NO heart surgery
YES NO pacemaker
YES NO hepatitis, jaundice, liver disease
YES NO kidney disease
YES NO autoimmune disease, AIDS
YES NO blood transfusion
YES NO kidney disease
YES NO radiation therapy or chemotherapy
YES NO tumor, growth, or cancer

OVER