HEALTH HISTORY

Patient Name_____ Date of Birth_____

1. Have you been a patient in the hospital during the past two years?..... ☐ Yes ☐ No
2. Have you been under the care of a physician during the past two years?.. ☐ Yes ☐ No
3. Have you taken any medications or drugs during the past two years?..... ☐ Yes ☐ No
4. When you walk up stairs or take a walk, do you have to stop because of pain in your chest, or shortness of breath, or because you are very tired?..... ☐ Yes ☐ No
5. Do your ankles swell during the day? ..... ☐ Yes ☐ No
6. Do you ever wake up from sleep short of breath?..... ☐ Yes ☐ No
7. Are you on a special diet?..... ☐ Yes ☐ No
8. Has your medical doctor ever said you have a cancer or tumor?..... ☐ Yes ☐ No
9. **Women only:** Are you taking birth control pills?..... ☐ Yes ☐ No
   Are you pregnant? ☐ Yes ☐ No If yes, what month? _____

Physician's Name_____ Phone_____

Do you have, or have you ever had:

- ☐ Abnormal Bleeding
- ☐ Alzheimers/Dimentia
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Cancer - Tumor
- ☐ Colitis
- ☐ Congenital Heart Defect
- ☐ COPD
- ☐ Cosmetic Surgery
- ☐ Diabetes IDDM
- ☐ Diabetes NIDDM
- ☐ Difficulty Breathing
- ☐ Fainting Spells
- ☐ Fever Blisters
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Hay Fever
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis A/ Hep B / or Hep C
- ☐ High Blood Pressure
- ☐ HIV + AIDS
- ☐ High Cholesterol
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Migraine Headaches
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis/Osteopenia
- ☐ Other Conditions (List)_____
  _____
- ☐ Pneumocystis ☐ Shingles
- ☐ Pacemaker / Defibrillator
- ☐ Radiation Therapy
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Thyroid Problem
- ☐ Tuberculosis
- ☐ Ulcers

MEDICATIONS: Please list (or show us your own printed record) all prescriptions and non-prescription medications. Use the back of this form if you need more room and let us know you wrote there.

☐ **TAKE NO MEDICATIONS**

_____

ALLERGY to Medications: ☐ Penicillin ☐ Codeine ☐ Other _____

ALLERGY to: ☐ Latex ☐ Dental Anesthetic ☐ Other _____

ABOVE INFORMATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE

The undersigned hereby authorize Dr. Reger to take x-rays, study models, photographs, or any other diagnostic aids deemed necessary to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Reger to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient) _____ and further authorize and consent that Dr. Reger choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for services provided in this office for my dependents or myself is mine; due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance charge will be added to any balance over 90 days. All treatment costs, regardless of insurance are the responsibility of the patient. In the event insurance does not pay, the patient is responsible for the balance.

Patient Signature_____Date_____

Employee Review Signature_____ Date_____