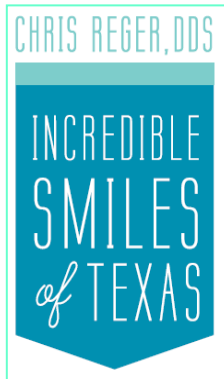


HEALTH HISTORY



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:

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

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 _____