Dr Sarkis L. Aznavour
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Confidential Health History Form

Today's Date_____ Patient name: _____ Birthdate_____

Primary care physician's name_____ Tel_____

Your pharmacy's name_____ Tel_____

- **Do you have any of the following diseases or problems?**

□ yes □ no Active tuberculosis
□ yes □ no Persistent cough greater than 3 week duration
□ yes □ no Cough that produces blood
□ yes □ no Been exposed to anyone with active tuberculosis

***** IMPORTANT: If you answer <u>YES</u> to any of the four questions above, please stop and return this form to the receptionist.*****

- **Do you have any allergies?** □ yes □ no (If yes, check all that apply)

□ Latex (rubber) □ Foods □ Penicillin □ Codeine or other narcotics
□ Iodine □ Hay fever/seasonal □ Sulfa drugs □ Other (specify)_____
□ Nickel or other metals □ Dental anesthetics □ Aspirin _____

- **Do you have a family history of any of the following?** (Check all that apply)

□ Diabetes □ Heart disease/problems □ Cancer or tumor (specify) _____
□ Bleeding disorders □ High cholesterol □ Other (specify)_____

- **Please list all medications you are currently taking or have taken within the last 3 months.** (Include all over-the-counter medicines, vitamins, and supplements)

_____
_____
_____

- **Please answer the following questions:**

1) Please describe your **general health**: □ good □ fair □ poor
2) Date of last physical exam_____ Results normal?_____

□ yes □ no 3) Has there been any **change in your general health** in the past year?
□ yes □ no 4) Have you had **unexplained weight loss or gain** in the past 6 months?
□ yes □ no 5) Are you currently under the care of a physician?
□ yes □ no 6) Do you have any **organ transplants**? If yes, please describe _____
□ yes □ no 7) Do you have any **artificial joints** (hip, knee replacements, etc.), or are you scheduled for orthopedic joint surgery? If so, have you had complications? _____
□ yes □ no 8) Are you taking, ever been treated with, or scheduled to begin taking oral or intravenous **bisphosphonates** (**Fosamax®, Boniva®**, **Actonel®, Aredia® , or Zometia®**) for osteoporosis, bone pain, Padget's disease, hypercalcemia, myeloma, or cancer? Date treatment began?_____
□ yes □ no 10) Have you ever taken Fen-Phen or other **medications for weight loss**?
□ yes □ no 11) Have you ever had **cosmetic surgery**? If yes, please describe _____
□ yes □ no 12) Do you use **recreational drugs** or controlled substances?
□ yes □ no 13) Do you use **tobacco** (smoking, snuff, chew, bidis)?
If so, _____ per day? How many years _____?
□ yes □ no 14) Do you drink **alcoholic beverages**? If yes, how much usually per week? _____
□ yes □ no 15) Have you **ever been hospitalized or visited the emergency room** for any reason? If yes, please describe reason and list date_____
_____
□ yes □ no 16) Have you had a recent **fever or night sweats**?

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Rev 08/14

Today's Date_____ **Patient name:** _____ **Birthdate**_____

- **Do you currently or have you ever had any of the following conditions?**

CARDIOVASCULAR

□ yes □ no Chest pain (Angina)
□ yes □ no Swollen ankles or feet
□ yes □ no Shortness of breath
□ yes □ no Hardening of arteries
□ yes □ no Heart disease or circulation problems
□ yes □ no Congestive heart failure
□ yes □ no Heart attack
□ yes □ no Heart surgery
□ yes □ no Heart valve replaced
□ yes □ no Heart murmur
□ yes □ no Prolapsed or damaged heart valve
□ yes □ no Pacemaker or defibrillator
□ yes □ no High or low blood pressure
□ yes □ no Heart infection (endocarditis)
□ yes □ no Irregular heartbeat (arrythmia)
□ yes □ no Congenital heart disease
□ yes □ no Rheumatic heart disease or fever
□ yes □ no Scarlet fever
□ yes □ no Stroke

HEAD AND NECK

□ yes □ no Headaches (migraine, tension)
□ yes □ no Snoring or sleep apnea
□ yes □ no Glaucoma or eye disease
□ yes □ no Earaches or hearing problems
□ yes □ no Hearing aid
□ yes □ no Sinusitis, sinus problems
□ yes □ no Difficulty swallowing
□ yes □ no Swollen neck glands
□ yes □ no Recent sore throat or hoarseness
□ yes □ no Neck ache
□ yes □ no Injury to face, head, or neck
□ yes □ no Jaw pain

HEMA/ENDO/IMMUNE

□ yes □ no Bruise easily
□ yes □ no Bleeding problem
□ yes □ no Blood in urine or stool
□ yes □ no Blood transfusion. List date_____
□ yes □ no Anemia
□ yes □ no Denied permission to give blood
□ yes □ no Cancer or tumor
□ yes □ no Radiation treatment or chemotherapy
□ yes □ no Diabetes
□ yes □ no Thyroid or adrenal gland disease
□ yes □ no Rheumatoid arthritis
□ yes □ no Arthritis
□ yes □ no Osteoporosis
□ yes □ no Skin disease or rash
□ yes □ no Cortisone medicine
□ yes □ no Autoimmune disease such as lupus,

RESPIRATORY

□ yes □ no Asthma
□ yes □ no Bronchitis or emphysema
□ yes □ no Tuberculosis

GASTROINTESTINAL/GENITOURINARY

□ yes □ no Eating disorder or malnutrition
□ yes □ no Frequent vomiting
□ yes □ no Heartburn
□ yes □ no Ulcers or colitis
□ yes □ no Diarrhea
□ yes □ no Constipation
□ yes □ no Blood in stool
□ yes □ no Jaundice (yellow skin or eyes)
□ yes □ no Hepatitis A B C other (**please circle**)
□ yes □ no Liver disease
□ yes □ no Excessive thirst
□ yes □ no Frequent urination
□ yes □ no Bladder infection
□ yes □ no Trouble urinating or blood in urine
□ yes □ no Kidney stones
□ yes □ no Kidney or bladder disease
□ yes □ no Dialysis
□ yes □ no Herpes
□ yes □ no HIV/AIDS
□ yes □ no Sexually transmitted disease

NEUROMUSCULAR/NEUROLOGIC

□ yes □ no Fainting
□ yes □ no Seizures (epilepsy)
□ yes □ no Numbness or paralysis
□ yes □ no Muscle weakness or multiple sclerosis
□ yes □ no Bell's Palsy
□ yes □ no Backaches
□ yes □ no Dizziness or vertigo
□ yes □ no Blurred vision
□ yes □ no Stiffness or painful joints
□ yes □ no Neurological problems
Specify_____
□ yes □ no Mental health disorder
Specify_____
□ yes □ no Psychiatric or emotional counseling
□ yes □ no Depression
□ yes □ no Anxiety
□ yes □ no Drug use or drug addiction
□ yes □ no Alcohol abuse or addition

WOMEN ONLY

□ yes □ no Currently or could be pregnant
If yes, no. of wks_____
□ yes □ no Currently nursing
□ yes □ no Taking birth control pills

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□ yes □ no	lichen planus, pemphigus, or Sjogren's Blood disease such as lymphoma, myeloma, leukemia	□ yes □ no □ yes □ no	Taking hormones Do you menstruate regularly?

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- **Do you currently or have you ever had any diseases, problems, surgeries or conditions not listed on the previous pages? □ yes □ no. If yes, please describe**

_____
_____
_____
_____
_____

I certify that I have read and understand the above information. I acknowledge that I have answered every question on this form truthfully and accurately to the best of my ability. I understand the importance of a truthful health history, and that my dentist and his staff will rely on this information for treating me. If ever my health or medications change, I will promptly inform my dentist. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. The practice of dentistry involves treating the whole person. If my dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment. I authorize my dentist to contact my physician. I will not hold my dentist or any member of his staff responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Patient's signature: _____ **Date**_____
(If patient is a minor, parent or legal guardian signature required)

Parent/legal guardian name (for minors only)**:** _____

Office use only: Pulse _____ HR _____/min Resp _____/min

Doctor's Comments: _____
_____
_____
_____
_____
_____

Reviewed By
(Dentist's signature): _____ **Date**_____