Stephen A. Los, DDS

Confidential Health History

Patient Name:_____ Soc. Sec. No.:_____ Birth Date:_____

I. CIRCLE APPROPRIATE ANSWER (leave Blank if you do not understand question):

1. Yes No Is your health good? Name of M.D.:_____
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 three years?
   If YES, why?_____
4. Yes No Are you being treated by a physician now? For what?_____
   Date of last medical exam:_____ Date of last dental exam:_____
5. Yes No Have you had problems with prior dental treatment? Please explain:_____
6. Yes No Are you in pain now?

II. HAVE YOU EXPERIENCED:

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

III. DO YOU HAVE OR HAVE YOU HAD:

29. Yes No Heart disease?
30. Yes No Heart attack, heart defects?
31. Yes No Heart murmurs or Rheumatic Fever?
32. Yes No Osteonecrosis?
33. Yes No Stroke, hardening of arteries?
34. Yes No High blood pressure?
35. Yes No Asthma, TB, emphysema, other lung diseases?
36. Yes No Hepatitis, other liver disease?
37. Yes No Stomach problems, ulcers?
38. Yes No Allergies to: drugs, foods, medications, latex?
39. Yes No Family history of diabetes, heart problems, tumors?
40. Yes No AIDS?
41. Yes No Tumors, cancer?
42. Yes No Arthritis, rheumatism?
43. Yes No Eye disease?
44. Yes No Skin diseases?
45. Yes No Anemia?
46. Yes No VD (syphilis or gonorrhea)?
47. Yes No Herpes?
48. Yes No Kidney, bladder disease?
49. Yes No Thyroid, adrenal disease?
50. Yes No Diabetes?

IV. DO YOU HAVE OR HAVE YOU HAD:

51. Yes No Psychiatric care?
52. Yes No Radiation treatments?
53. Yes No Chemotherapy?
54. Yes No Prosthetic heart valve?
55. Yes No Artificial joint?
56. Yes No Hospitalization?
57. Yes No Blood transfusions?
58. Yes No Surgeries?
59. Yes No Pacemaker?
60. Yes No Contact lenses?

V. ARE YOU TAKING:

61. Yes No Recreational drugs?
62. Yes No Drugs, medications, over-the-counter medicines (including Aspirin), natural/homeopathic remedies?
63. Yes No Tobacco in any form?
64. Yes No Alcohol?
65. Yes No Herbals?

Please list:_____

VI. WOMEN ONLY:

66. Yes No Are you or could you be pregnant or nursing?
67. Yes No Taking birth control pills?

VII. ALL PATIENTS:

68. Yes No Have you ever taken fen-phen?
70. Yes No Fosamax or other bisphosphonates?
69. Yes No Do you have or have you had any other disease or medical problems NOT listed on this form?

If so, please explain:_____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I have received and understand the "Notice of Privacy Practices" which became effective February 17, 2010. I have received a copy of the "Dental Material Fact Sheet" published May 2004 as required by law.

Patient's signature:_____ Date:_____
Doctor's signature:_____ Date:_____
Hygienist's signature:_____ Date:_____