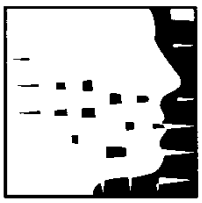

Ben F. Tarsitano, DDS, MD

Diplomate, American Board of
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CONFIDENTIAL HEALTH HISTORY

Patient Name _____ Birth Date _____

CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes No Is your general health good?
   If NO, explain: _____
2. Yes No Has there been a change in your health within the last year?
   If YES, explain: _____
3. Yes No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain: _____
4. Yes No Are you being treated by a physician now? If YES, explain: _____
   Date of last medical exam: _____ Reason for exam: _____
5. Yes No Have you had problems with prior dental treatment?
   If YES, explain: _____
   Date of last dental exam: _____ Reason for exam: _____
6. Yes No Are you in pain now?
   If YES, explain: _____

HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING? (Please circle YES or NO for each)

Yes No	Chest pain (angina)	Yes No	Blood in stools	Yes No	Frequent vomiting
Yes No	Fainting spells	Yes No	Diarrhea or constipation	Yes No	Jaundice
Yes No	Recent significant weight loss	Yes No	Frequent urination	Yes No	Dry mouth
Yes No	Fever	Yes No	Difficulty urinating	Yes No	Excessive thirst
Yes No	Night sweats	Yes No	Ringing in ears	Yes No	Difficulty swallowing
Yes No	Persistent cough	Yes No	Headaches	Yes No	Swollen ankles
Yes No	Coughing up blood	Yes No	Dizziness	Yes No	Join pain or stiffness
Yes No	Bleeding problems	Yes No	Blurred vision	Yes No	Shortness of breath
Yes No	Blood in urine	Yes No	Bruise easily	Yes No	Sinus problems

Other: _____

HAVE YOU EVERY HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle YES or NO for each)

Yes No	Heart disease	Yes No	AIDS/HIV	Yes No	Psychiatric care
Yes No	Family history of heart disease	Yes No	Surgeries	Yes No	Osteoporosis
Yes No	Heart attack	Yes No	Hospitalization	Yes No	Thyroid disease
Yes No	Artificial joint	Yes No	Diabetes	Yes No	Asthma
Yes No	Stomach problems or ulcers	Yes No	Family history of diabetes	Yes No	Hepatitis
Yes No	Heart defects	Yes No	Tumors or cancer	Yes No	Sexually transmitted disease
Yes No	Heart murmurs	Yes No	Chemotherapy	Yes No	Herpes
Yes No	Rheumatic fever	Yes No	Radiation	Yes No	Canker or cold sores
Yes No	Skin disease	Yes No	Arthritis, rheumatism	Yes No	Anemia
Yes No	Hardening of arteries	Yes No	Emphysema or other lung disease	Yes No	Liver disease
Yes No	High blood pressure	Yes No	Kidney or bladder disease	Yes No	Eye disease
Yes No	Seizures	Yes No	Stroke	Yes No	Transplants
Yes No	Cosmetic surgery	Yes No	Eating disorders	Yes No	Tuberculosis

Other: _____

ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please circle YES or NO for each)

Yes	No	Aspirin	Yes	No	Valium or other sedatives	Yes	No	Codeine or other narcotics
Yes	No	Penicillin or other antibiotics	Yes	No	Latex	Yes	No	Food
Yes	No	Nitrous oxide	Yes	No	Local anesthetic	Yes	No	Metal

Others: _____

ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS? (Please circle YES or NO for each)

Yes	No	Recreational drugs	Yes	No	Tobacco in any form	Yes	No	Antibiotics
Yes	No	Over-the-counter medications	Yes	No	Alcohol	Yes	No	Supplements
Yes	No	Weight loss medications	Yes	No	Bisphosphonates (Fosamax)	Yes	No	Aspirin
Yes	No	Anti-depressants	Yes	No	Herbal supplements			

Please list all prescription medications:

_____

_____

_____

_____

WOMEN ONLY (Please circle YES or NO for each)

Yes No Are you or could you be pregnant? If YES, how far along? _____

Yes No Are you nursing?

Yes No Are you taking birth control pills?

ALL PATIENTS (Please circle YES or NO for each)

Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?

If YES, please explain:

_____

_____

Yes No Have you ever been pre-medicated for dental treatment? If YES, why? _____

Yes No Have you ever taken Fen-Phen? If YES, when? _____

Yes No **Is there any issue or condition that you would like to discuss with the dentist in private?**

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's signature: _____ Date: _____

Physician's Name: _____ Phone #: _____

I certify that I have read and understand this form. 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. Further, I will not hold my dentist, or any member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____ _____ _____

Signature of Patient (Parent or Guardian) Date Signature of Dentist Date