

Bruce Grbach, DDS
Health History

Patient's Name _____ How do you wish to be addressed? _____

Answers to the following questions are for our records only and will be considered confidential.

Date of last Physical exam _____ Physician's Name _____

Date of last Dental exam _____ Dentist's Name _____

Date of last dental radiographs _____ (use approximate date if unsure of actual date)

Have you been a patient in a hospital during the past two years? _____

Have you been under the care of a physician during the past two years? _____

Circle any of the following which you have had or have at present:

- | | | | |
|------------------|--------------------|-----------------------|------------------|
| Heart Failure | Emphysema | HIV Positive | Tobacco Products |
| Heart Disease | Cough | Hepatitis | Alcoholism |
| Heart Attack | Tuberculosis (TB) | Liver Disease | High Blood |
| Angina Pectoris | Hay Fever | Yellow Jaundice | Pressure |
| Asthma | Sinus Trouble | Blood Transfusion | Ulcers |
| Heart Murmur | Allergies | Drug Addiction | Cancer |
| Rheumatic Fever | Diabetes | Hemophilia | Leukemia |
| Scarlet Fever | Thyroid Disease | Venereal Disease | Anemia |
| Artificial Heart | Radiation Therapy | Cold Sores | Stroke |
| Valve | Chemotherapy | Herpes | Heart Defects |
| Heart Pacemaker | Arthritis | Epilepsy or Seizures | Birth Defects |
| Heart Surgery | Rheumatism | Fainting | Bruise Easily |
| Artificial Joint | Cortisone Medicine | Nervousness | Dizzy Spells |
| Glaucoma | Kidney Trouble | Psychiatric Treatment | |
| Pain in Joints | Sickle Cell Anemia | Mental Retardation | |

List any other medical conditions not included above _____

List any allergic reactions (i.e. itching, rash, swelling of hands, feet or eyes, or made sick by penicillin, aspirin, codeine) to any drugs, medications, metals, or latex? _____

Have you ever had any excessive bleeding requiring special treatment? _____

Do you have a history of chemical dependency? _____ How long have you been in recovery? _____

Are you currently using cocaine, ecstasy or methamphetamine? _____

WOMEN: Are you pregnant now? _____

WOMEN: Are you taking oral contraceptives? _____

List all medications, vitamins and supplements the amount and why you take the medication.

Person to contact in case of Emergency: _____

Telephone Number: _____

I acknowledge that the information provided for this medical history on the above named person is accurate and complete. I also acknowledge that it is my duty to inform Dr. Grbach of any medical changes or changes in medications.

Signature: _____ Date: _____

Reviewed by: _____ Date: _____