Dr Heather Feray Bohan, DDS, PA
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HEALTH HISTORY
| DOB:

Summary

Medical Conditions	**none listed**
Allergies	**none listed**
Medications	**none listed**

Medical History

Health conditions and or medication that you may be taking, could have an important interrelationship with the dentistry you wil receive. Thank you for answering the following questions.

General Health Information	
Are you under a physician's care now?	
Have you ever been hospitalized or had a major operation?	
Have you ever had a serious head or neck injury?	
Are you taking any medications, pills, or drugs?	
Do you take, or have you taken, Phen-Fen or Redux?	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	
Are you on a special diet?	
Do you use tobacco?	
Do you use controlled substances?	
Women are you:	
Pregnant/Trying to get pregnant?	
Nursing?	
Taking oral contraceptives?	
Are you allergic to any of the following?	
Aspirin	
Penicillin	
Codeine	
Acrylic	
Metal	
Latex	
Sulfa Drugs	
Local Anesthetics	
Other?	
Do CURRENTLY you have, any of the following?	

AIDS/HIV Positive	
Alzheimer's Disease	
Anaphylaxis	
Anemia	
Angina	
Arthritis/Gout	
Artificial Heart Valve	
Artificial Joint	
Asthma	
Blood Disease	
Blood Transfusion	
Breathing Problems	
Bruise Easily	
Cancer	
Chemotherapy	
Chest Pains	
Cold Sores/Fever Blisters	
Congenital Heart Disorder	
Convulsions	
Yellow Jaundice	
Cortisone Medicine	
Diabetes	
Drug Addiction	
Easily Winded	
Emphysema	
Epilepsy or Seizures	
Excessive Bleeding	
Excessive Thirst	
Fainting Spells/Dizziness	
Frequent Cough	
Frequent Diarrhea	
Frequent Headaches	
Genital Herpes	
Glaucoma	
Hay Fever	
Heart Attack/Failure	
Heart Murmur	
Heart Pacemaker	
Heart Trouble/Disease	
Hemophilia	
Hepatitis A	
Hepatitis B or C	

Herpes	
High Blood Pressure	
High Cholesterol	
Hives or Rash	
Hypoglycemia	
Irregular Heartbeat	
Kidney Problems	
Leukemia	
Liver Disease	
Low Blood Pressure	
Lung Disease	
Mitral Valve Prolapse	
Osteoporosis	
Pain in Jaw Joints	
Parathyroid Disease	
Psychiatric Care	
Radiation Treatments	
Recent Weight Loss	
Renal Dialysis	
Rheumatic Fever	
Rheumatism	
Scarlet Fever	
Shingles	
Sickle Cell Disease	
Sinus Trouble	
Spina Bifida	
Stomach/Intestinal Disease	
Stroke	
Swelling of Limbs	
Thyroid Disease	
Tonsillitis	
Tuberculosis	
Tumors or Growths	
Ulcers	
Venereal Disease	
Comments:	

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient's signature: Date:

General Dentist's signature: Date: