Osprey Dental, LLC

HEALTH HISTORY

Personal Physician Name:_____Phone:_____

Personal Physician Address:_____

YES NO

☐ ☐ 1. Have you been hospitalized within the past 2 years? For What?_____

☐ ☐ 2. Are you currently being treated by a physician? For What?_____

☐ ☐ 3. Are you currently taking any medicines or drugs? Please list?_____

_____

☐ ☐ 4. Have you ever received counseling for excessive use of alcohol and/or prescription drugs?

☐ ☐ 5. Are you allergic to any drugs? Please list:_____

☐ ☐ 6. Have you ever had a skin rash or other reaction to metal jewelry? To What?_____

☐ ☐ 7. Are you allergic to any metals? Please list?_____

☐ ☐ 8. Do you bleed excessively upon injury?

☐ ☐ 9. Are you pregnant?

☐ ☐ 10. Have you ever been involved with dental/medical legal activity?

☐ ☐ 11. Do you take, or have you taken, bisphosphonates such as FOSAMAX, BONIVA, ACTONEL, Or RECLAST?

CIRCLE ANY OF THE FOLLOWING CONDITIONS THAT YOU HAVE HAD OR NOW HAVE

A. AIDS	G. Epilepsy	M. Jaundice	S. Stroke
B. Alzheimer's Disease	H. Glaucoma	N. Kidney Problems	*T. Tuberculosis*
C. Arthritis	I. Heart Murmur	O. Low Blood Pressure	U. Other Diseases*
D. Asthma	J. Heart Problem*	P. Nervous Breakdown Or Psychiatric Therapy	
E. Cancer	K. Hepatitis	Q. Rheumatic Fever	
F. Diabetes	L. High Blood Pressure	R. Sexually Transmitted Diseases	

* If you circled either J or U - describe condition:_____

_____

Patient Name Printed:	Date:
Patient Signature (Parent if Child):	Date: