



David R. Patton, DDS, Inc
33001 Solon Road Suite 201 Solon, Ohio 44139
440-248-2035

Health History

Physicians Name _____ **Date of Last Examination** _____

Have you ever taken any of the group of drugs collectively referred to as "phen-phen?" These include combinations of Ionimin, Adipex, Fastin, (brand names of phentermine), Pondimin (fonfluramine) and Redux (dexfenfluramine). Yes___ No___

Place a mark on "yes" or "no" to indicate if you have ever had any of the following

- | | | | | | |
|---------------------------|--------------|-----------------------|--------------|------------------------|--------------|
| Aids/HIV | Yes___ No___ | Emphysema | Yes___ No___ | Radiation Treatment | Yes___ No___ |
| Anemia | Yes___ No___ | Epilepsy | Yes___ No___ | Respiratory Disease | Yes___ No___ |
| Arthritis | Yes___ No___ | Fainting or Dizziness | Yes___ No___ | Rheumatic Fever | Yes___ No___ |
| Artificial Heart Valves | Yes___ No___ | Glaucoma | Yes___ No___ | Scarlet Fever | Yes___ No___ |
| Artificial Joints | Yes___ No___ | Headaches | Yes___ No___ | Shortness of Breath | Yes___ No___ |
| Asthma | Yes___ No___ | Heart Murmur | Yes___ No___ | Sinus Trouble | Yes___ No___ |
| Back Problems | Yes___ No___ | Heart Problems | Yes___ No___ | Skin Rash | Yes___ No___ |
| Bleeding abnormally, with | | Hepatitis, type___ | Yes___ No___ | Special Diet | Yes___ No___ |
| Extractions or surgery | Yes___ No___ | Herpes | Yes___ No___ | Stroke | Yes___ No___ |
| Blood Disease | Yes___ No___ | High Blood Pressure | Yes___ No___ | Swollen Feet or Ankles | Yes___ No___ |
| Cancer | Yes___ No___ | Jaundice | Yes___ No___ | Swollen Neck Glands | Yes___ No___ |
| Chemical Dependency | Yes___ No___ | Jaw Pain | Yes___ No___ | Thyroid Problems | Yes___ No___ |
| Chemotherapy | Yes___ No___ | Kidney Disease | Yes___ No___ | Tonsillitis | Yes___ No___ |
| Circulatory Problems | Yes___ No___ | Liver Disease | Yes___ No___ | Tuberculosis | Yes___ No___ |
| Congenital Heart Lesions | Yes___ No___ | Low Blood Pressure | Yes___ No___ | Tumor or growth on | |
| Cortisone Treatments | Yes___ No___ | Mitral Valve Prolapse | Yes___ No___ | head or neck | Yes___ No___ |
| Cough, Persistent or | | Nervous Problems | Yes___ No___ | Ulcer | Yes___ No___ |
| Bloody | Yes___ No___ | Pacemaker | Yes___ No___ | Venereal Disease | Yes___ No___ |
| Diabetes | Yes___ No___ | Psychiatric Care | Yes___ No___ | Weight Loss | |
| | | | | Unexplained | Yes___ No___ |

Do you wear contact lenses? Yes___ No___

Women:

Are you Pregnant? Yes___ No___ Due Date _____

Taking Birth Control Yes___ No___

Are you Nursing? Yes___ No___

Medications:

List any medications you are currently taking and the corresponding diagnosis

Pharmacy Name _____

Phone (____) _____

Allergies:

___ Aspirin ___ Local Anesthetic

___ Barbiturates ___ Penicillin

___ Codeine ___ Sulfa

___ Iodine ___ Other _____

___ Latex _____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand providing incorrect information can be dangerous to my health. I authorize David R. Patton, DDS Inc. to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health care practitioners.

X _____
 Signature of patient (or parent, if minor)