REVIEWED_____

DATE_____

JEFFREY N. KENNEY, D.D.S.

HEALTH HISTORY

Patient's Name _____
LAST FIRST MI

Age_____ Weight _____ Height_____ Sex: ❑ Male ❑ Female

Name of Physician _____

Name of Dentist _____

Referred By_____

PLEASE ANSWER ALL QUESTIONS BY CIRCLING (Y) OR (N)
THIS OFFICE WILL HOLD THIS INFORMATION THE UTMOST CONFIDENCE.

1. Are you in good health? ..... Y N
2. Has there been any change in your general health in the past year? ..... Y N
3. Date of last physical exam? _____
4. Are you now under a physician's care for a particular problem? Y N
5. Have you had any serious illnesses, operations or hospitalizations? If so, describe ..... Y N

_____

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6. Do you have or have you ever had (please circle)
   - A. Rheumatic Fever or Rheumatic Heart Disease? ..... Y N
   - B. Congenital Heart Disease? ..... Y N
   - C. Cardiovascular Disease (heart trouble, heart attack, heart murmur, coronary heart disease, angina, high blood pressure, stroke, palpitations, heart surgery, pacemaker)? ..... Y N
   - D. Lung Disease (asthma, emphysema, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)? ..... Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting, Psychiatric Treatment, Dizziness, Nervous Disorder or Breakdown? ..... Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion, Easy Bruising? ..... Y N
   - G. Liver Disease (jaundice, hepatitis)? ..... Y N
   - H. Kidney Disease? ..... Y N
   - I. Diabetes? ..... Y N
   - J. Thyroid Disease (goiter)? ..... Y N
   - K. Arthritis? ..... Y N
   - L. Stomach Ulcers or Colitis? ..... Y N
   - M. Glaucoma? ..... Y N
   - N. Frequent or Recurring Mouth Sores? ..... Y N
   - O. Implants placed anywhere in your body (heart valve, hip, knee)? ..... Y N
   - P. Radiation (x-ray) Treatment for Cancer? ..... Y N
   - Q. Clicking or popping of jaw joint, pain in ear, difficulty opening mouth, grinding or clenching teeth? ..... Y N
   - R. Sinus or nasal problems or snoring? ..... Y N
   - S. Any disease, drugs or transplant operation that has depressed your immune system? ..... Y N

7. Are you using or taking any of the following:
   - A. Thyroid Medications? ..... Y N
   - B. Antibiotics or Sulfa Drugs? ..... Y N
   - C. Anticoagulants (blood thinners)? ..... Y N
   - D. High Blood Pressure? ..... Y N
   - E. Steroids (Cortisone, Prednisone, etc.)? ..... Y N
   - F. Tranquilizers (Valium, etc.)? ..... Y N
   - G. Insulin, Diabenese, or similar drug? ..... Y N
   - H. Digitalis, Inderal, Nitroglycerine, Calcium Channel Blockers, Procardia, or other Heart Medicine? ..... Y N
   - I. Aspirin or Ibuprofen (Motrin, Naprosyn, etc.) ..... Y N
     How much daily? _____
   - J. Marijuana or other "Street Drugs" ..... Y N
   - K. Antihistamines or Decongestants? ..... Y N
   - L. Bisphosphonates Drugs (Zometa, Aredia, Boniva, Actonel, Fosamax)? Other _____ ..... Y N
   - M. Are you taking any other regular medications, pills or drugs? ..... Y N
     If Yes, please list: _____

     _____

8. Are you allergic or have you reacted badly to:
   - A. Local Anesthetic (Novocaine, etc.)? ..... Y N
   - B. Penicillin, Amoxicillin, Cephalosporins, or other antibiotics? Y N
   - C. Barbiturates, Sedatives, etc.? ..... Y N
   - D. Aspirin or Ibuprofen? ..... Y N
   - E. Codeine or other painkillers? ..... Y N
   - F. Latex or Rubber Products? ..... Y N
   - G. Other allergies or reactions? ..... Y N
     If Yes, please list: _____

     _____

9. Do you smoke or chew tobacco? ..... Y N
   If Yes, how many per day: _____
10. Frequently use alcohol/recreational drugs ..... Y N
11. Do you have any other disease or problem not listed above that the doctor should know about? ..... Y N
12. If female, are you pregnant? ..... Y N
13. Do you or might you have sleep apnea? ..... Y N

FOR FEMALE PATIENTS ONLY

A. If you are using contraceptives it is important that you understand that antibiotics and other medications may interfere with the effectiveness of oral contraceptives; therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills after the course of antibiotics or other medications is completed. Please consult with your physician for further guidance.

B. If you are pregnant, possibly pregnant, or trying to become pregnant, surgery, anesthetics or any other medication may significantly harm your developing baby, especially during the first trimester. Please advise your doctor if there is any chance of your being pregnant.

I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL HEALTH HISTORY TO ASSIST IN PROVIDING THE BEST CARE POSSIBLE.

Signature of Person Completing Health History _____Date _____

MEDICAL UPDATE: I HAVE READ MY HEALTH HISTORY ABOVE AND CONFIRM THAT IT ADEQUATELY REFLECTS MY MEDICAL CONDITION, PAST AND PRESENT.

DATE	EXCEPTIONS OR CHANGES	PATIENT'S SIGNATURE	DOCTOR INITIALS
_____	_____	_____	_____