BANDON COASTAL DENTAL
HEALTH HISTORY

Name:____ Date of Birth:____________________

Have you ever taken any of the group of drugs collectively referred to as "Fen-Phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of Phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).

☐ Yes ☐ No

Have you ever taken Fosamex or other biophosphonates? ☐ Yes ☐ No

Place a mark on "Yes or "No" to indicate if you have any of the following:

☐ Yes	☐ No	Arthritis, Rheumatism	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Respiratory Problems
☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Artificial Joints	☐ Yes	☐ No	Rheumatic Fever
☐ Yes	☐ No	Blood Disorders	☐ Yes	☐ No	Stroke	☐ Yes	☐ No	Epilepsy
☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Alcohol/Drug Abuse
☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Lupus	☐ Yes	☐ No	Sinus Problems
☐ Yes	☐ No	Smoker/Chew Tobacco	☐ Yes	☐ No	Hepatitis Type____	☐ Yes	☐ No	TMJ/Jaw Pain
☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Teeth Grinding
☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Transplanted Organs
☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No	Endocrine Problems	☐ Yes	☐ No	Tuberculosis
☐ Yes	☐ No	Cancer	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No	Diabetes
☐ Yes	☐ No	Chemotherapy	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Circulatory Problems
☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	Mitral Valve Prolapse

WOMEN:

☐ Yes ☐ No Are you pregnant? Due Date:_________________ ☐ Yes ☐ No Nursing

MEDICATIONS

List any medications, vitamins, and/or supplements that you are currently taking:

ALLERGIES

☐ Yes	☐ No	Aspirin	☐ Yes	☐ No	Local Anesthetic	☐ Yes	☐ No	Penicillin
☐ Yes	☐ No	Codeine	☐ Yes	☐ No	Sulfa	☐ Yes	☐ No	Iodine
☐ Yes	☐ No	Latex	☐ Yes	☐ No	Other__________________________________			

Signature: Date: