

SYMPTOMS Have you experienced any of the following in the last 3 months? *(Please check all that apply)*

<input type="checkbox"/> Chest pain (angina)	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Jaundice
<input type="checkbox"/> Fainting spells	<input type="checkbox"/> constipation	<input type="checkbox"/> Dry mouth
<input type="checkbox"/> Unexplained weight loss	<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Excessive thirst
<input type="checkbox"/> Fever	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Difficulty swallowing
<input type="checkbox"/> Night sweats	<input type="checkbox"/> Headaches	<input type="checkbox"/> Swollen neck glands
<input type="checkbox"/> Persistent cough	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Swollen ankles
<input type="checkbox"/> Coughing up blood	<input type="checkbox"/> Bruise easily	<input type="checkbox"/> Joint pain, stiffness
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Frequent vomiting	<input type="checkbox"/> Sinus problems

CONDITIONS Have you had or do you have any of the following? *(Please check all that apply)*

<input type="checkbox"/> Artificial joints (Type_____Year_____)	<input type="checkbox"/> Seizures	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Heart disease	<input type="checkbox"/> Cosmetic surgery	<input type="checkbox"/> Kidney or bladder disease
<input type="checkbox"/> Family history of heart disease	<input type="checkbox"/> Surgeries	<input type="checkbox"/> Eating disorders
<input type="checkbox"/> Heart attack	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Heart defects	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Heart murmurs	<input type="checkbox"/> Family history of diabetes	<input type="checkbox"/> Hepatitis (Type_____)
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Tumors	<input type="checkbox"/> Sexual transmitted disease
<input type="checkbox"/> Artificial heart valve	<input type="checkbox"/> Cancer	<input type="checkbox"/> Herpes
<input type="checkbox"/> Hardening of arteries	<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Canker or cold sores
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Radiation	<input type="checkbox"/> Anemia
<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Arthritis, rheumatism	<input type="checkbox"/> Liver disease
<input type="checkbox"/> Stroke	<input type="checkbox"/> Emphysema or other lung disease	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Asthma	<input type="checkbox"/> Transplant

CONDITIONS This information will not be released unless specifically authorized by patient.

CONTINUED... *(Please check all that apply)*

<input type="checkbox"/> HIV	<input type="checkbox"/> Treatments for emotional condition
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression

ALLERGIES Are you allergic to or have you had a reaction to any of the following?

(Please check all that apply)

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Metal
<input type="checkbox"/> Darvon	<input type="checkbox"/> Amoxicillin	<input type="checkbox"/> Novocain or Xylocaine
<input type="checkbox"/> Valium	<input type="checkbox"/> Sulfa	<input type="checkbox"/> Latex
<input type="checkbox"/> Demerol	<input type="checkbox"/> Erythromycin	<input type="checkbox"/> Iodine
<input type="checkbox"/> Codeine	<input type="checkbox"/> Tetracycline	<input type="checkbox"/> Acrylic
<input type="checkbox"/> Vicodin	<input type="checkbox"/> Food (type_____)	
<input type="checkbox"/> Percodan	<input type="checkbox"/> Nitrous Oxide	

Please list any other medications or substances you are or may be allergic to: _____

Name: _____

MEDICATIONS / SUBSTANCES

Are you taking or have you taken any of the following in the last 3 months? *(Please check all that apply)*

Antibiotics	Supplements	Recreational drugs.
Over-the-counter medicines	Aspirin Daily	Tobacco in any form
Weight loss medications	Blood Thinners (Coumadin)	Alcohol
Corticosteroids	Bisphosphonate (Fosamax)	

Please list all medications you are currently taking: _____

WOMEN ONLY

(Please check all that apply)

- Yes / No **Are you taking birth control pills?**
 Yes / No **Are you or could you be pregnant? If YES, what month?** _____
 Yes / No **Are you nursing?**

ALL PATIENTS

(Please check all that apply)

- Yes / No **Do you have or have you had any other diseases or medical problems NOT listed on this form?**
If YES, explain: _____
 Yes / No **Have you ever been pre-medicated for dental treatment? If YES, why:** _____
 Yes / No **Have you ever taken Pondimin or Fen-Phen? If YES, when:** _____
 Yes / No **Are you a smoker? If YES, how much do you smoke per day? How long have you smoked?** _____

ALL PATIENTS - SLEEP ASSESSMENT

(Please check all that apply)

- Yes / No **Have you ever been told you stop breathing while asleep?**
 Yes / No **Have you ever fallen asleep or nodded off while driving?**
 Yes / No **Have you ever woken up suddenly with shortness of breath, gasping or with your heart racing?**
 Yes / No **Do you feel excessively sleepy during the day?**
 Yes / No **Do you snore, or have you ever been told that you snore?**
 Yes / No **Have you had weight gain and found it difficult to lose?**
 Yes / No **Have you taken medication for, or been diagnosed with high blood pressure?**
 Yes / No **Do you kick or jerk your legs while sleeping?**
 Yes / No **Do you feel burning, tingling or crawling sensations in your legs when you wake up?**
 Yes / No **Do you wake up with headaches during the night or in the morning?**
 Yes / No **Do you have trouble falling asleep?**
 Yes / No **Do you have trouble staying asleep once you fall asleep?**

The practice of dentistry involves treating the whole person. If Dr. Solow determines that there may be a medically compromised situation, medical consultation may be needed prior to commencement of dental treatment.

Do you authorize Dr. Solow and/or his staff to contact your physician if necessary? YES NO

Physician's Name: _____ Office phone #: _____

ROBERT M. SOLOW, D.D.S., INC. – DENTAL PRACTICE POLICES

- We invite you to discuss with us any questions regarding our services. We are best able to address your dental needs, desires and concerns when there are open communications to assure mutual understanding between you and our staff.
- The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my or my child's medical status. I authorize the dental staff to perform necessary dental services for me/ my minor/child.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with our business manager. In the absence of a preexisting financial arrangement, if your account is greater than 90 days past due, you may be held liable for legal fees, collection agency fees, interest charges and any other expenses incurred in collection of your account.
- In an effort to improve patient scheduling and care, we respectfully request that you advise us of your need to cancel or change your appointment at least **24 hours** prior to your reserved time. Please extend this courtesy both to us and to other patients who may benefit from your appointment time. If you find it necessary to change or cancel an appointment at the last minute, there will be a charge of **\$45.00** for each hour of appointed time. While we understand that unforeseen emergencies and illness may occur, we ask that you consider the value of our time and the needs of other patients.
- I certify that I have read and understand the above statements of Office Policy and Health History which I completed. I have answered each question accurately and to the best of my knowledge. I will continue to inform this office and staff of any change in my health status and/or medication. I also consent to Dr. Solow's office using my cell phone to contact me regarding any appointments, insurance information or account matters. Further, I will not hold Dr. Solow, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature: _____ **Date:** _____
(Signature of legal Guardian or Parent if Patient is under 18 years of age)

MEDICAL UPDATES (Office use only)

<u>Date</u>	<u>Changes to Health History</u>	<u>Dentist or Hygienist Initials</u>

You can save and email this form or print and bring it with you to the office.