

FAMILY HEALTH INFORMATION

Some health conditions are the result of hereditary spinal weaknesses. Information that you can furnish us pertaining to your immediate family members (brothers, sisters, parents and grandparents) will give us a better understanding of your total health needs.

RELATIONSHIP TO YOU	FAMILY MEMBER PRESENT AND PAST HEALTH PROBLEMS

MEDICATIONS

List Medications you are currently taking

Pharmacy _____ Phone _____

- | | |
|---|--|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Other (please list) |
| <input type="checkbox"/> Iodine | _____ |
| <input type="checkbox"/> Latex | _____ |
| <input type="checkbox"/> Local Anesthetic | _____ |

CHECK ANY SYMPTOM(S) OR CONDITION(S) BELOW THAT YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST YEAR

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Depression/Nervousness | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Poor Appetite |
| <input type="checkbox"/> Arm Pain or Numbness | <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Itching | <input type="checkbox"/> Prostate Problem |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Rapid Heartbeat |
| <input type="checkbox"/> Back Pain or Numbness | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Lack of Bladder Control | <input type="checkbox"/> Rectal Bleeding |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Earache | <input type="checkbox"/> Leg Pain or Numbness | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Ear Discharge | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Feet Pain or Numbness | <input type="checkbox"/> Loss of Hearing | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Fever | <input type="checkbox"/> Loss of Sleep | <input type="checkbox"/> Scars |
| <input type="checkbox"/> Bowel Changes | <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Loss of Weight | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Shoulder Pain or Numbness |
| <input type="checkbox"/> Brights Disease | <input type="checkbox"/> Gas | <input type="checkbox"/> Lumbago | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Measles | <input type="checkbox"/> Sore That Won't Heal |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Hand Pain or Numbness | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Stomach Aches or Pains |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Headache | <input type="checkbox"/> Mumps | <input type="checkbox"/> Sweats |
| <input type="checkbox"/> Change in Moles | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Nausea | <input type="checkbox"/> Swelling Ankles |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Neck Pain or Numbness | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Neuralgia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Herpes | <input type="checkbox"/> Neuritis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chills | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Crossed Eyes | <input type="checkbox"/> Hip Pain or Numbness | <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Vision Flashes |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Hives | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Vomiting Blood |

CHECK DEGREE OF HABITS BELOW. ALL INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL.

	Heavy	Casual	Light	None		Heavy	Casual	Light	None		Heavy	Casual	Light	None
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sugar/Sugar Products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Sweeteners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Salty Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I certify that the above information is correct to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible to errors or omissions that I have made in the completion of this form.

Signature _____ Date _____