Gregory R. Bowen
909 N.E. Loop 410, Suite 703, San Antonio, TX 78209

Patient Health History

Patient Name _____ Date of Birth _____

Welcome to our office. Will you please fill out this short Health History form so we may be aware of any problems you have or have had. Use the Additional Comments at the end of the form to include any extra information. Thank you.

Please circle YES or NO or fill in where appropriate

Primary reason for this appointment _____

Has there been any change in your health since last year? ..... YES NO
Have you had any serious illness, operation or hospitalization within the past 5 years? ..... YES NO
Are you taking any medicine(s) including non-Prescription? _____
Do you have or have you had any of the following diseases or problems?

a. Damaged heart valves, artificial valves or murmur ..... YES NO
b. Rheumatic Heart Disease ..... YES NO
c. High blood pressure ..... YES NO
d. Heart trouble, heart attack, angina, or any other heart condition ..... YES NO
    1. Chest pain on exertion ..... YES NO
    2. Shortness of breath after mild exercise? ..... YES NO
e. Allergy i.e. foods, plants latex, etc. _____
f. Sinus trouble ..... YES NO
g. Asthma or hay fever ..... YES NO
h. Fainting spells or seizures ..... YES NO
i. Hepatitis, jaundice or liver disease ..... YES NO
j. Thyroid problems ..... YES NO
k. Respiratory problems ..... YES NO
l. Arthritis or painful, swollen joints ..... YES NO
m. Stomach ulcer or hyperacidity ..... YES NO
n. Kidney trouble ..... YES NO
o. Tuberculosis ..... YES NO
p. Epilepsy or neurological disorder ..... YES NO
q. Cancer ..... YES NO
r. Autoimmune diseases ..... YES NO

Have you had abnormal bleeding? ..... YES NO
Do you have any blood disorder such as anemia? ..... YES NO
Have you ever had treatment for a tumor or growth? ..... YES NO
Are you allergic or have you had reaction to:

a. Local anesthetics ..... YES NO
b. Penicillin or antibiotics ..... YES NO
c. Sulfa drugs ..... YES NO
d. Barbiturates or sleeping pills ..... YES NO
e. Aspirin ..... YES NO
f. Iodine ..... YES NO
g. Codeine or other narcotics ..... YES NO
h. Other _____

Do you now or have you ever used tobacco products? ..... YES NO
Have you had any serious trouble associated with previous dental treatment? ..... YES NO
Do you have any other condition or disease you think we should know about
but would prefer to discuss privately rather than writing them down? ..... YES NO

Women:

Are you pregnant? …… YES NO

Are you nursing? …… YES NO

Are you taking birth control pills? …… YES NO

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 that providing incorrect information can be dangerous to my health. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

X _____

Signature of patient or guardian Date

MEDICAL HISTORY UPDATE:

SIGNATURE	COMMENTS	DATE