Christopher Jaghab D.D.S.

Medical Health History

General Health (please check): Excellent ❑ Good ❑ Fair ❑ Poor ❑

Physician's Name_____Telephone #_____Date of Last Physical_____

Are you currently under the care of a physician (MD, DO)?	❑ Yes ❑ No
Do you or have you ever smoked?	❑ Yes ❑ No
Do you consume alcohol?	❑ Yes ❑ No
Are you taking any medications now?	❑ Yes ❑ No If yes, please list **all** medications on back of page
Have you ever taken Fosamax, Actonel, or Bisphosphonates (Aredia or Zometa)?	❑ Yes ❑ No
Are you allergic to any medications, foods, latex, etc.?	❑ Yes ❑ No

Please list_____

Do you have or have you ever had any of the following?

Heart Disease	❑ Yes ❑ No	Cancer	❑ Yes ❑ No
Rheumatic Fever	❑ Yes ❑ No	X-ray Treatments for Cancer	❑ Yes ❑ No
Heart Murmur or Arrhythmia	❑ Yes ❑ No	Chemotherapy	❑ Yes ❑ No
Mitral Valve Prolapse	❑ Yes ❑ No	Drastic Weight Loss	❑ Yes ❑ No
Heart Valve Replacement	❑ Yes ❑ No	Immune System Disorder	❑ Yes ❑ No
Artificial Joint Replacement	❑ Yes ❑ No	AIDS or HIV Positive	❑ Yes ❑ No
Chest Pain or Shortness of Breath	❑ Yes ❑ No	Sexually Transmitted Disease	❑ Yes ❑ No
Swollen Ankles	❑ Yes ❑ No	Hepatitis	❑ Yes ❑ No
Chronic Fatigue or Tire Easily	❑ Yes ❑ No	Jaundice	❑ Yes ❑ No
Abnormal Blood Pressure	❑ Yes ❑ No	Kidney or Liver Disease	❑ Yes ❑ No
Severe or Frequent Headaches	❑ Yes ❑ No	Prolonged Bleeding or Bruising	❑ Yes ❑ No
Fainting, Seizures or Dizziness	❑ Yes ❑ No	Blood Disease or Hemophilia	❑ Yes ❑ No
Stroke	❑ Yes ❑ No	Anemia	❑ Yes ❑ No
Persistent Cough	❑ Yes ❑ No	Excessive Urination and/or Thirst	❑ Yes ❑ No
Emphysema	❑ Yes ❑ No	Diabetes	❑ Yes ❑ No
Tuberculosis or Lung Disease	❑ Yes ❑ No	Rheumatoid or Arthritic Condition	❑ Yes ❑ No
Frequent Colds or Sore Throat	❑ Yes ❑ No	Osteoporosis	❑ Yes ❑ No
Asthma or Hay Fever	❑ Yes ❑ No	Ulcers or Gastric Reflux	❑ Yes ❑ No
Sinus Trouble	❑ Yes ❑ No	Epilepsy	❑ Yes ❑ No
Eye, Ear, Nose or Throat Disorder	❑ Yes ❑ No	Drug or Alcohol Addiction	❑ Yes ❑ No
Glaucoma	❑ Yes ❑ No	Anxiety or Mental Disorders	❑ Yes ❑ No
Lymph Node Enlargement or Swollen Glands	❑ Yes ❑ No	Eating Disorders	❑ Yes ❑ No
		Thyroid or Endocrine Disorders	❑ Yes ❑ No

Women Only:

Are you pregnant?	❑ Yes ❑ No	If yes, expected delivery date_____
Are you nursing?	❑ Yes ❑ No	
Are you taking birth control pills?	❑ Yes ❑ No	
Have you reached menopause?	❑ Yes ❑ No	If yes, are you on Hormone Replacement Therapy? ❑ Yes ❑ No

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that Dr. Christopher Jaghab and his staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold Dr. Christopher Jaghab, or any other member of his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian_____Date_____

Dentist's Signature_____ Date_____