Kurt Buska, D.D.S.

Family & Cosmetic Dentistry

Patient Health History

First Name: _____ MI: _____ Last: _____ Date of Birth: _____

Physician's Name: _____ City: _____ State: _____

When was your last complete physical exam? _____

Circle the appropriate answer and provide details in the space to the right of the question.

Additional space is available on the back of this page.

YES / NO Are you taking any medication or substances? Please list:_____

YES / NO Are you allergic to any medication? _____

YES / NO Do you have any other allergies or hives? _____

YES / NO Do you have problems with penicillin, antibiotics, anesthetics or medications? _____

YES / NO Are you sensitive to latex? _____

YES / NO Are you pregnant or suspect you may be? _____

YES / NO Do you use any birth control medications?_____

YES / NO Have you ever been treated for or told you have heart disease? _____

YES / NO Do you have a pacemaker, artificial heart valve implant or have been diagnosed with mitral valve prolapse? _____

YES / NO Have you ever had rheumatic fever? If yes, when? _____

YES / NO Are you aware of any heart murmurs? _____

YES / NO Do you have high or low blood pressure? _____

YES / NO Do you have any artificial joints or prosthesis? _____

YES / NO Have you ever had a serious illness or major surgery? If so, explain: _____

YES / NO Have you ever had radiation or chemo treatment for a tumor, growth or other condition? _____

YES / NO Have you ever taken Fosamax, Zometa, Aredia or any other oral or intravenous bone loss therapy (bisphosphonates)? _____

YES / NO Have you been treated for bone tumors, excessive calcium in your blood, or osteoporosis? _____

YES / NO Do you have inflammatory diseases such as arthritis or rheumatism? _____

YES / NO Do you have any blood disorders, such as anemia, leukemia, sickle cell, etc.? _____

YES / NO Have you ever bled excessively after being cut or injured? _____

YES / NO Do you have any stomach, kidney, liver, or other organ problems? _____

YES / NO Are you diabetic? _____

YES / NO Do you have fainting or dizzy spells? _____

YES / NO Do you have asthma? _____

YES / NO Do you have epilepsy or seizure disorders? _____

YES / NO Have you tested HIV positive? _____

YES / NO Do you have AIDS? _____

YES / NO Have you had or do you test positive for hepatitis? _____

YES / NO Do you or have you had T.B.? _____

YES / NO Do you smoke, chew, use snuff or any other forms of tobacco? _____

YES / NO Do you consume more than one or two alcoholic beverages a day? _____

YES / NO Do you use any controlled substances? _____

YES / NO Have you had psychiatric treatment? _____

YES / NO Have you taken fenfluramine, fenfluramine with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products?

YES / NO Do you have any disease condition or problem not listed? If so, explain: _____

YES / NO Is there anything else we should know about your health that we haven't covered in the form? _____

YES / NO Would you like to speak to the Doctor privately about any problem? _____

I CERTIFY THAT THE ABOVE INFORMATIUON IS COMPLETE AND ACCURATE.

PATIENT'S/GUARDIAN'S SIGNATURE: _____ DATE: _____

DENTIST'S SIGNATURE: _____ DATE: _____