Andrew B. Wurtz DDS

Name: ______________________________

Health Information

Have you ever had any of the following?

Yes No Blood Disease:

____
IF YES PLEASE EXPLAIN

Yes No Heart Disease:

____
IF YES PLEASE EXPLAIN

Yes No Kidney Disease:

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IF YES PLEASE EXPLAIN

Yes No Liver Disease:

____
IF YES PLEASE EXPLAIN

Yes No Lung Disease:

____
IF YES PLEASE EXPLAIN

Yes No Allergies to any Medication, Latex or Other Substance:

____
IF YES PLEASE EXPLAIN

Yes No Adverse reaction to Dental Treatment:

____
IF YES PLEASE EXPLAIN

Yes No Hospitalization or needed emergency care during the past two years:

____
IF YES PLEASE EXPLAIN

Yes No Under the care of a physician:

____
IF YES: DOCTORS NAME

____
PHONE NUMBER

Yes No AIDS, or HIV
Yes No Artificial Joints or Heart Valves
Yes No Asthma
Yes No Averaged 3 or more alcoholic drinks/day
Yes No Cancer
Yes No Cortisone Medicine
Yes No Cold Sores

Yes No Diabetes
Yes No Dizziness or Fainting
Yes No Drug Addiction
Yes No Epilepsy
Yes No Excessive Bleeding
Yes No Heart Murmur
Yes No Hepatitis
Yes No Herpes Virus
Yes No High Blood Pressure

Yes No Nervous Disorders
Yes No Pacemaker
Yes No Possibly Pregnant
Yes No Radiation Treatment
Yes No Rheumatic Fever
Yes No Stroke
Yes No Tuberculosis
Yes No Taken **Fen-Phen**, or **Redux**?
Yes No Used any **Bisphosphonates** medications?

Yes No **Do you have any other health problems; disease, or conditions not listed:**

____
IF YES PLEASE EXPLAIN

____
IF YES PLEASE EXPLAIN

Yes No **Are you taking any medications?**

____
MEDICATION CONDITION TREATED

____
MEDICATION CONDITION TREATED

The answers to all of the preceding questions are true and correct. If I ever have a change in my health or medications I will inform the doctor at my next appointment. If deemed advisable, I grant permission for my Physician to be contacted for details and advice.

____
SIGNATURE OF PATIENT, PARENT OR GUARDIAN

Date: ______________