



**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	HEALTH PROBLEMS ANY FAMILY MEMBER HAS HAD OR HAS NOW

**MEDICATIONS**

List medications you are currently taking

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- Aspirin
- Barbiturates
- Codeine
- Iodine
- Latex
- Local Anesthetic
- Penicillin
- Sulfa
- Other (please list) \_\_\_\_\_

Pharmacy \_\_\_\_\_ Phone \_\_\_\_\_

**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 for any errors or omissions that I may have made in the completion of this form.

Signature \_\_\_\_\_ Date \_\_\_\_\_

