



Garret Family Dental Care
 15009 West Bell Road, Suite 175
 Surprise, Arizona 85374-3213
 Phone 623.476.8100
 Fax 623.792.5311
 garrettdental@gmail.com

HEALTH HISTORY

PATIENT NAME _____ BIRTH DATE _____

PRIMARY PHYSICIAN _____ PHONE _____

DATE OF LAST VISIT? _____ DATE OF LAST COMPLETE PHYSICAL EXAM? _____

Have you ever taken any of the group collectively referred to as "fen-phen"? (Lanimin, Adipex, Fastin, Phentermine, Pondimin, Fenfluramine, Redux, or Dexfenfluramine) Yes No

CURRENTLY HAVE OR HAVE HISTORY OF ANY OF THE FOLLOWING (check all boxes that apply)

<input type="checkbox"/> Anemia <input type="checkbox"/> Angina/Chest Pain <input type="checkbox"/> Arthritis <input type="checkbox"/> Artificial Heart Valves <input type="checkbox"/> Artificial Joints: _____ (year) <input type="checkbox"/> Asthma <input type="checkbox"/> Back Problems <input type="checkbox"/> Bacterial Endocarditis <input type="checkbox"/> Bleeding Abnormally with Extractions/surgery <input type="checkbox"/> Blood Disease <input type="checkbox"/> Blood Thinner <input type="checkbox"/> Cancer <input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Circulatory Problems <input type="checkbox"/> Congenital Heart Lesions <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Cortisone Treatments <input type="checkbox"/> Cough, persistent or bloody <input type="checkbox"/> Diabetes <input type="checkbox"/> Dialysis <input type="checkbox"/> Dizziness/Fainting <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Glaucoma <input type="checkbox"/> Headaches <input type="checkbox"/> Head Injuries <input type="checkbox"/> Heart Attack: _____ (year) <input type="checkbox"/> Heart Disease <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Heart Problems <input type="checkbox"/> Heart Surgery: _____ (year) <input type="checkbox"/> Hemophilia <input type="checkbox"/> Hepatitis: _____ (type) <input type="checkbox"/> Herpes/Fever Blisters <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Jaundice <input type="checkbox"/> Jaw Pain <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Problems/Disease <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Lupus <input type="checkbox"/> Mental Disorders <input type="checkbox"/> Mitral Valve <input type="checkbox"/> Nervous Disorders <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Skin Rash <input type="checkbox"/> Special Diet <input type="checkbox"/> Stroke <input type="checkbox"/> Swollen Feet or Ankles <input type="checkbox"/> Swollen Neck Glands <input type="checkbox"/> Pacemaker <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Pins/Plates: _____ (year) <input type="checkbox"/> Radiation Treatment/Chemotherapy <input type="checkbox"/> Respiratory Problems <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Rheumatism <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Shingles <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Tumors/Growths on head/neck <input type="checkbox"/> Ulcers <input type="checkbox"/> Valley Fever <input type="checkbox"/> Venereal Disease <input type="checkbox"/> Weight Loss, unexplained <input type="checkbox"/> NONE
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X _____
 Signature of Patient or Responsible Party Date

Office Use Only

Dr. Todd S. Garrett (DDS1) _____ Signature of Doctor





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MEDICAL CONDITIONS (not listed on the previous page)	DRUGS & MEDICATIONS (that you are currently taking)	ALLERGIES (check all that apply)
<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> Asprin
<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> Barbiturates (sleeping pills)
<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> Codeine
<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> Epi
<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> Erythro
<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> Hay Fever
<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> Iodine
<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> Latex
<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> Local Anesthetic
<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> Penicillin
<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> Sulfa
<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> Tylenol
<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> Vicodin
<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
<input type="checkbox"/> NONE	<input type="checkbox"/> NONE	<input type="checkbox"/> NONE
<input type="checkbox"/> CHECK HERE IF YOU HAVE PROVIDED A LIST TO GARRETT DENTAL.	<input type="checkbox"/> CHECK HERE IF YOU HAVE PROVIDED A LIST TO GARRETT DENTAL.	<input type="checkbox"/> CHECK HERE IF YOU HAVE PROVIDED A LIST TO GARRETT DENTAL.

WOMEN ONLY (check all boxes that apply)

Pregnant **DUE DATE** _____ Nursing Contraceptives, prescription

X _____ **Date**

Signature of Patient or Responsible Party

_____ **Relationship** to Patient

Print name of Patient or Responsible Party

Office Use Only

Dr. Todd S. Garrett (DDS1)

Signature of Doctor



Creating Smiles to Remember