INCREDIBLE Smiles™

HEALTH HISTORY UPDATE

Your name _____
Address _____
City/State/Zip _____
Home phone _____ Cell phone _____
Email _____
Date of birth _____ Social Security # _____

Medical History

Are you allergic or made sick by Penicillin, aspirin, Codeine, or any other drugs or medications? _____
If yes, please list: _____

Please provide a date for the following if applicable:

Glaucoma (Wide or narrow angle?) _____ Artificial Joint/ Joint Replacement _____
Angina Pectoris _____ Mitrovalve Prolapse (MVP) _____
Tuberculosis (TB) _____ Chemotherapy (Cancer, Leukemia) _____
High Blood Pressure (What is normal for you?) _____
Heart Murmur (Are you functional or nonfunctional?) _____

Rheumatic Fever _____	Congenital heart lesions _____	Rheumatism _____
HIV _____	Scarlet Fever _____	Cortisone Medicine _____
AIDS _____	Artificial heart valve _____	Psychiatric Treatment _____
Liver disease _____	Heart failure _____	Drug Addictions _____
Hepatitis A _____	Heart Disease or Attack _____	Epilepsy _____
Hepatitis B _____	Heart Pacemaker _____	Fainting _____
Hepatitis C _____	Heart surgery _____	Nervousness _____
Yellow Jaundice _____	Hay Fever _____	Anorexia _____
Blood transfusion _____	Allergies or Hives _____	Bulimia _____
Hemophilia _____	Cough _____	Diabetes (Type I or II)_____
Anemia _____	Sinus trouble _____	Thyroid disease _____
Sickle Cell disease _____	Asthma _____	Ulcers _____
Kidney trouble _____	Emphysema _____	X-ray/Cobalt treatment_____
Stroke _____	Arthritis _____	Cold sores _____
Pain in jaw joints _____	Herpes _____	Pregnant? _____

Please list all current medications _____

Name and number of current physician _____

Have you ever taken Fen Phen or Redux and if so, did you have a cardio exam? _____

The information I have given is true and correct to the best of my knowledge. I will inform the doctor, assistant, hygienist if there is any change in my medical status.

_____ _____

Signature of guest or Guardian **Date** **Doctor Signature** **Date**

EPWORTH SLEEPINESS SCALE: How likely are you to doze off or fall asleep in the followingtt situations, in contrast to just feeling tired?ttThis refers to your usual way of life in recent times.ttEven if youtt have not done some of these things recently, try to work out how they would have affected you.ttUse thett following scale to mark the most appropriate box for each situation.

0= would never doze **1= slight chance of dozing**
2= moderate chance of dozing **3= high chance of dozing**

Sitting and reading	_____
Watching TV	_____
Sitting, inactive, in a public place (theater, meeting, etc)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____

Guest Name _____ **TOTAL** _____