SALMAN HUSSAIN D.M.D., INC.
DENTIST ANESTHESIOLOGIST ON CALL

HEALTH HISTORY

(PLEASE PRINT)

Name____ DOB _____/_____/_____
Last First M. I.

Have you had? (circle choice)	N0	Yes	Have you had? (circle choice)	NO	Yes
Recurrent Headache			Asthma		
Thyroid Disorder			Epilepsy/Seizures		
Hoarseness			Dizziness/Fainting with exercise		
Ear, Nose or throat problems			Head Injury/Concussion		
Bone/Joint problems			Stomach/Intestinal Problems		
Congenital Heart Disease			Diabetes		
Heart Murmur/Heart Disease			Eating Disorder		
Heart Palpitations			ADD/ADHD		
High/Low Blood Pressure			Tuberculosis		
Anemia/Sickle Cell			Phen-Fen use present/past?		
Bleeding Disorders: Hemophilia/Other			Alcohol Abuse		
Hepatitis			Drug Abuse		
Kidney/Bladder Disorders			Rheumatic/Scarlet fever		
Pneumonia/Bronchitis			Emotional Problems Specify below:		
Tuberculosis			History of Tobacco Use		
Seasonal Allergies/Hay Fever					
Surgeries:					
Hospitalizations:					

Allergies:
Medication Allergies:
Medication currently taking:

Any other disease, illness, past surgeries, permanent disabilities, or explanations of any marked concerns from the list above?____

____

Are you currently being treated by a health care professional? NO, if YES explain:

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____

____

Patient/Guardian			
Last Name, First Name, MI			**E-mail address**
Address			
City	**State**	**Zip**	
Telephone	**Date of Birth**	**Age**	**Gender** Male Female

1. Emergency Contacts: Persons to be contacted in case of an emergency; list two		
1. Name	**Relationship**	**Home Phone**
Address		**Business Phone**
2. Name	**Relationship**	**Home Phone**
Address		**Business Phone**

PRIMARY CARE PHYSICIAN Name	
Address	**Phone**
	Fax