

# Stephen A. Mabry, D.D.S.

**Pateint Health History:** New Patients Fill Out Left Half of Page

Please Print Name: \_\_\_\_\_

Circle the Appropriate Answer to Each Question:

1. Do you have any dental or health problems you wish to discuss with Dr. Mabry?..... Yes No
2. Other than routine, are you currently under a physician's care?..... Yes No
3. Physician's Name: \_\_\_\_\_ Ph.: \_\_\_\_\_
4. Do you snore?..... Yes No
5. Are you allergic to the following: (Circle Answer)  
Local Anesthetics (novacaine)..... Yes No  
Penicillin or other antibiotics..... Yes No  
Pain Reliever ..... Yes No  
Metal..... Yes No

If "Yes" for any, or if other allergic reaction, please explain:

\_\_\_\_\_

6. If female,  
Are you or do you suspect you are pregnant?..... Yes No  
Are you nursing a baby?..... Yes No
7. Are you taking any medications?..... Yes No  
If "Yes", please list them with the reason: (Use back if necessary.)

\_\_\_\_\_

\_\_\_\_\_

8. Do you have, or have you had, any of the following?  
Anemia (severe)..... Yes No  
Angina..... Yes No  
Asthma..... Yes No  
Bulimia..... Yes No  
Cancer..... Yes No  
Cardiac pacemaker..... Yes No  
Chemotherapy/Radiation therapy..... Yes No  
Diabetes..... Yes No  
Epilepsy, convulsions or seizures..... Yes No  
Fainting..... Yes No  
Heart Attack..... Yes No  
Heart trouble..... Yes No  
Hemophilia..... Yes No  
Hepatitis..... Yes No  
High or low blood pressure (circle which)..... Yes No  
HIV Positive or AIDS (circle which)..... Yes No  
Joint replacement in last 2 years..... Yes No  
Liver disease (or other internal organ)..... Yes No  
Mitral Valve Prolapse..... Yes No  
Respiratory problems..... Yes No  
Rheumatic Fever (anytime in your past)..... Yes No  
Sinus or ear infections (frequent)..... Yes No  
Tuberculosis..... Yes No

If "Yes" for any, or if other health problem, please explain:

\_\_\_\_\_

\_\_\_\_\_

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

Update (For Future Appointments)

Have there been any changes in your health or medications since your last visit?.....Yes No

Have there been any changes in your insurance, address, e-mail, or phone numbers (home, work, cell) since your last visit?.....Yes No

If yes, please explain: (Use back if necessary.)

\_\_\_\_\_

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

Update (For Future Appointments)

Have there been any changes in your health or medications since your last visit?.....Yes No

Have there been any changes in your insurance, address, e-mail, or phone numbers (home, work, cell) since your last visit?.....Yes No

If yes, please explain: (Use back if necessary.)

\_\_\_\_\_

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

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Have there been any changes in your health or medications since your last visit?.....Yes No

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If yes, please explain: (Use back if necessary.)

\_\_\_\_\_

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

Update (For Future Appointments)

Have there been any changes in your health or medications since your last visit?.....Yes No

Have there been any changes in your insurance, address, e-mail, or phone numbers (home, work, cell) since your last visit?.....Yes No

If yes, please explain: (Use back if necessary.)

\_\_\_\_\_

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