ALLAN K. BERNSTEIN, D.D.S

MEDICAL HEALTH HISTORY

Are you currently taking any of the following medications?

Name		Dose/day	Name		Dose/Day
Anitbiotics			Tylenol		
Anti-inflammatory			Insulin		
Anti-seizure			Orinase, etc.		
Sulfa Drugs			Digitalis		
Anticoagulants			Stomach Meds		
HBP* Drugs			Oral Contraceptives		
Cortisone (Steriods)			Pain Meds		
Sleeping Pills			Antidepressants		
(Barbiturates)			Vitamins or		
Antihistamines			Supplements		
Asprin			Other		

*High Blood Pressure

	Now	Past	No		Now	Past	No		Now	Past	No
Allergies	O	O	O								
Asthma	O	O	O	Fatigue easily	O	O	O	Arteriosclerosis	O	O	O
Overweight/obese	O	O	O	Chronically tired	O	O	O	Stroke	O	O	O
Chronic cough	O	O	O	Fainting spells	O	O	O	Atrial fibrillations	O	O	O
Sinus problems	O	O	O	Dizziness	O	O	O	Heart disease	O	O	O
Depression	O	O	O	Chest pains	O	O	O	Heart palpitations	O	O	O
Memory loss	O	O	O	Muscle soreness	O	O	O	Pacemaker	O	O	O
Muscle spasms	O	O	O	Osteo-arthritis	O	O	O	Alcoholism	O	O	O
Diabetes I or II	O	O	O	Fast pulse	O	O	O	Drug problems	O	O	O
Hypoglycemia	O	O	O	Fibromyalgia	O	O	O	Dentures	O	O	O
Multiple sclerosis	O	O	O	HIV	O	O	O	Dental appliance	O	O	O
Leg cramps	O	O	O	Hypertensive (BP)	O	O	O	Heartburn	O	O	O
Psychological care	O	O	O	Learning disability	O	O	O	Ulcers	O	O	O
Hyperactivity	O	O	O	**Sleep apnea**	O	O	O	Parkinson’s disease	O	O	O
Swallowing problems	O	O	O	Insomnia	O	O	O	Jaw Pain	O	O	O
Chronic pain	O	O	O	Sleeping difficulty	O	O	O				

Do you have any blood disease such as anemia? Yes No

Do you have any disease, condition, or problem not listed here that you think we should know about? Yes No

Please explain: ______

Personal History:

Please list your most serious illnesses, injuries and operation history:

______

Please list any known allergies (other than medications): ______

______ Signature of Patient ______ Date

______ Signature of Doctor ______ Date

8-9-12