



Andrea Larhs, DDS, PS
www.drlarhs.com

1501 4th Avenue
Suite 312
Seattle, WA 98101

Tel 206-292-9900
Fax 206-233-2724

HEALTH HISTORY

Patient Name _____ Date _____

Physician's Name / Phone Number _____ Date of last visit _____

Do you have or have you ever had any of the following conditions listed below – please check any that apply

- | | |
|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer (surgery / radiation/ chemotherapy) |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Skin problems |
| <input type="checkbox"/> Autoimmune disorder | <input type="checkbox"/> Joint replacement |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Muscle / bone problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bisphosphanate use
(Fosamax, Boniva, Actonel, Aridia, Zometa) |
| <input type="checkbox"/> COPD (emphysema, bronchitis) | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> TB | <input type="checkbox"/> Jaw pain |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Neurologic / neuromuscular disorder |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Nervous problems / depression |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> STD / HIV / AIDS |
| <input type="checkbox"/> High blood pressure _____ | <input type="checkbox"/> Eye conditions |
| <input type="checkbox"/> Angina / chest pain | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Pacemaker / defibrillator | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Other heart / circulatory problems | <input type="checkbox"/> Smoking – how much _____ |
| <input type="checkbox"/> Bleeding disorder / abnormal bleeding | <input type="checkbox"/> Alcohol – how many drinks per week _____ |
| <input type="checkbox"/> Blood transfusions | <input type="checkbox"/> Recreational drug use |
| <input type="checkbox"/> Renal/ kidney problems /dialysis | |
| <input type="checkbox"/> Gastrointestinal problems / ulcers / reflux | |
| <input type="checkbox"/> Liver problems / jaundice | |
| <input type="checkbox"/> Hepatitis Type _____ | |

Women: Are you pregnant? Y N Due Date: _____ Are you nursing? Y N

MEDICATIONS	ALLERGIES	SURGERIES/HOSPITALIZATIONS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

