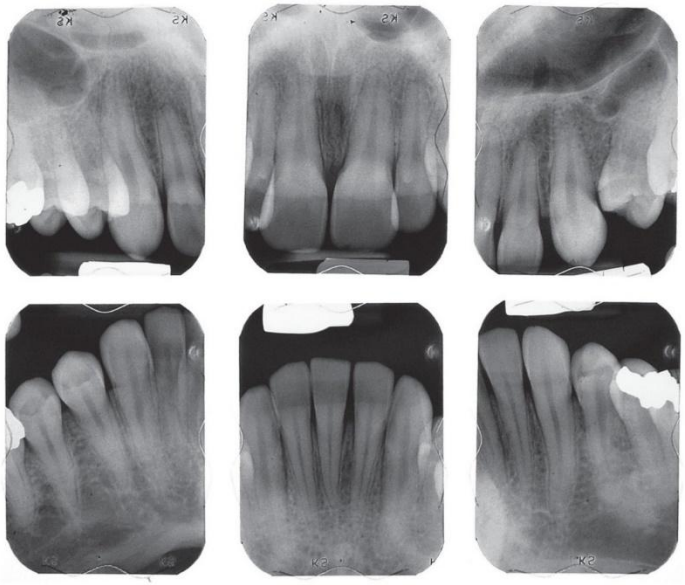
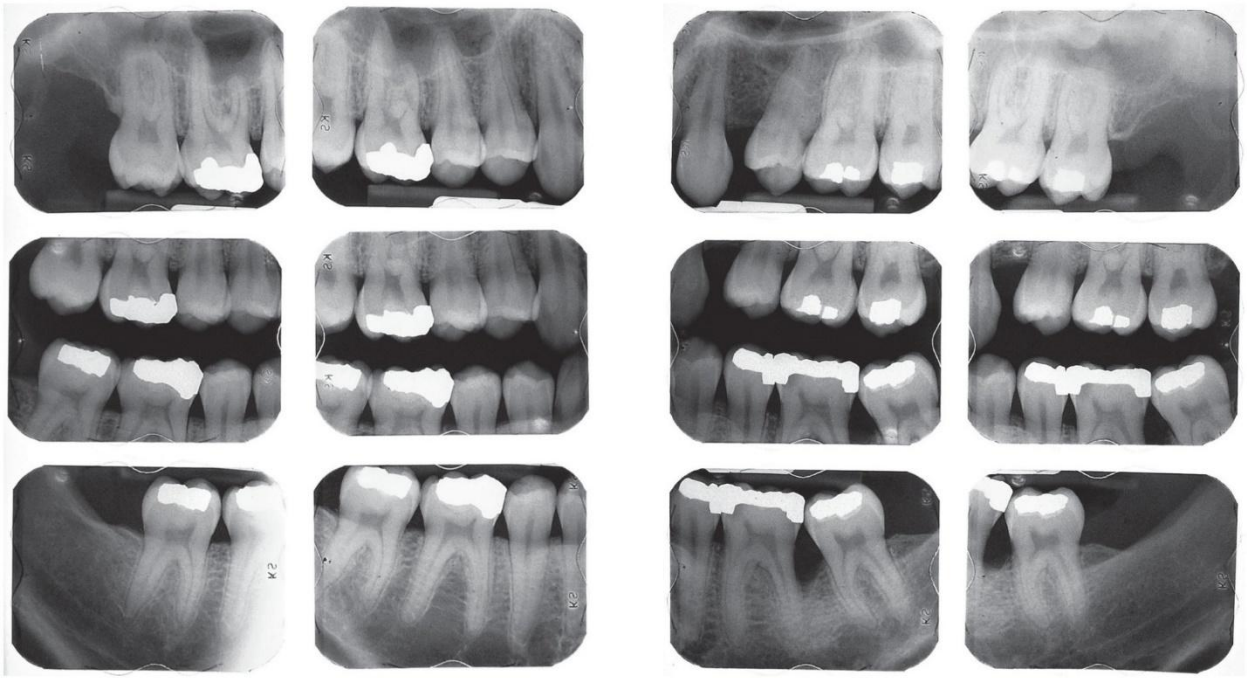


A

Right

Left



B

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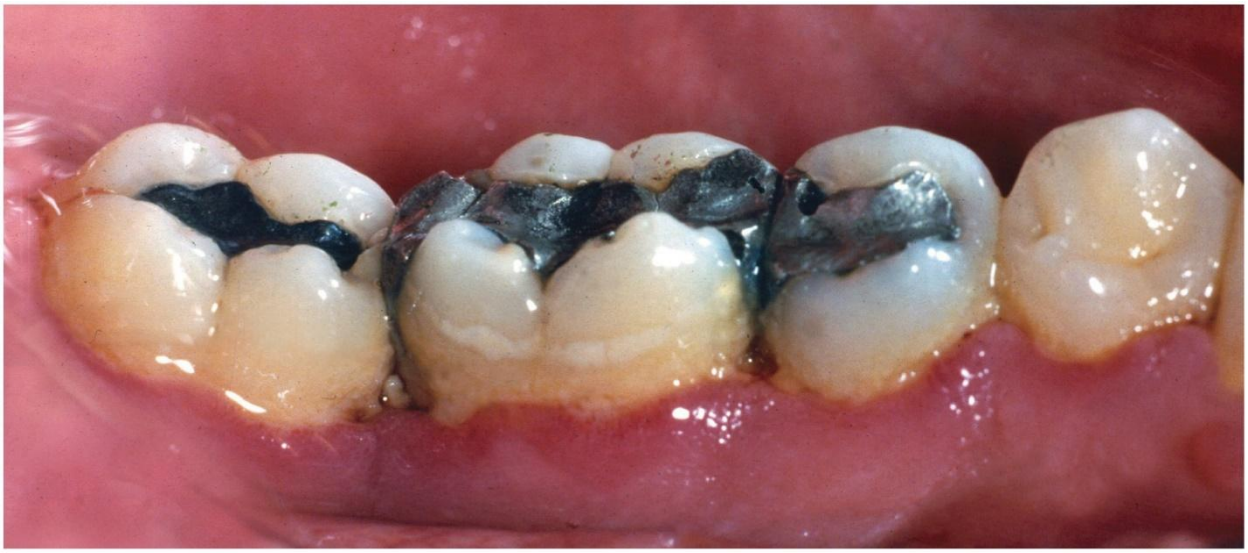

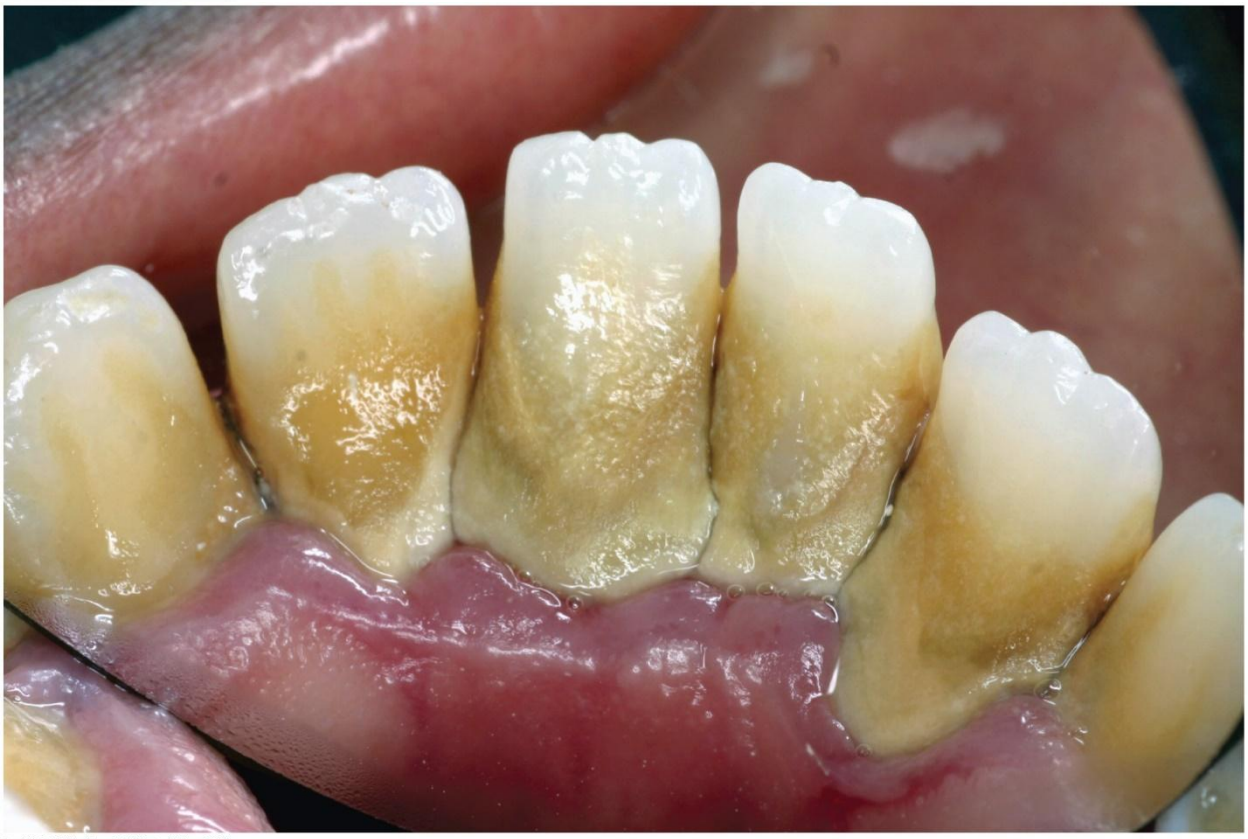

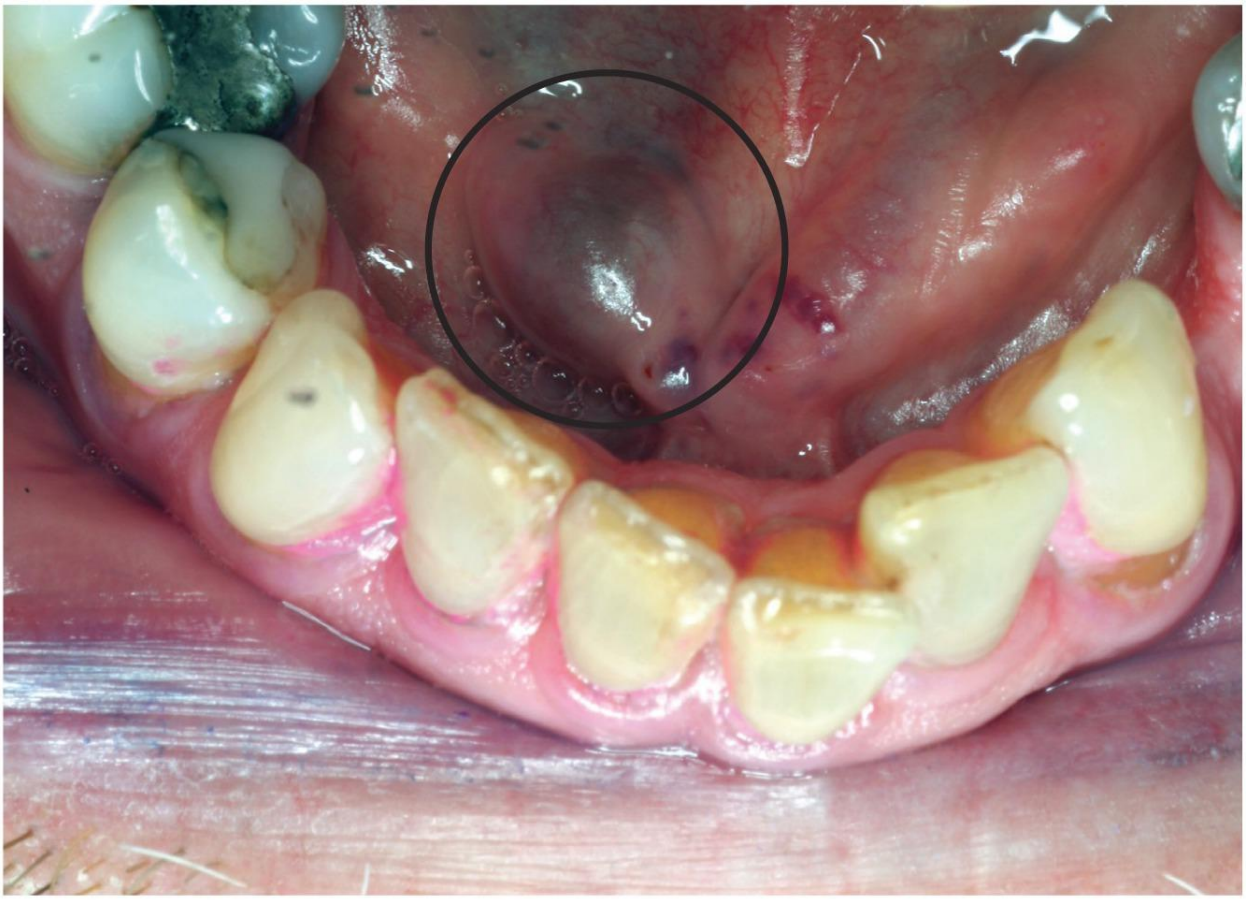

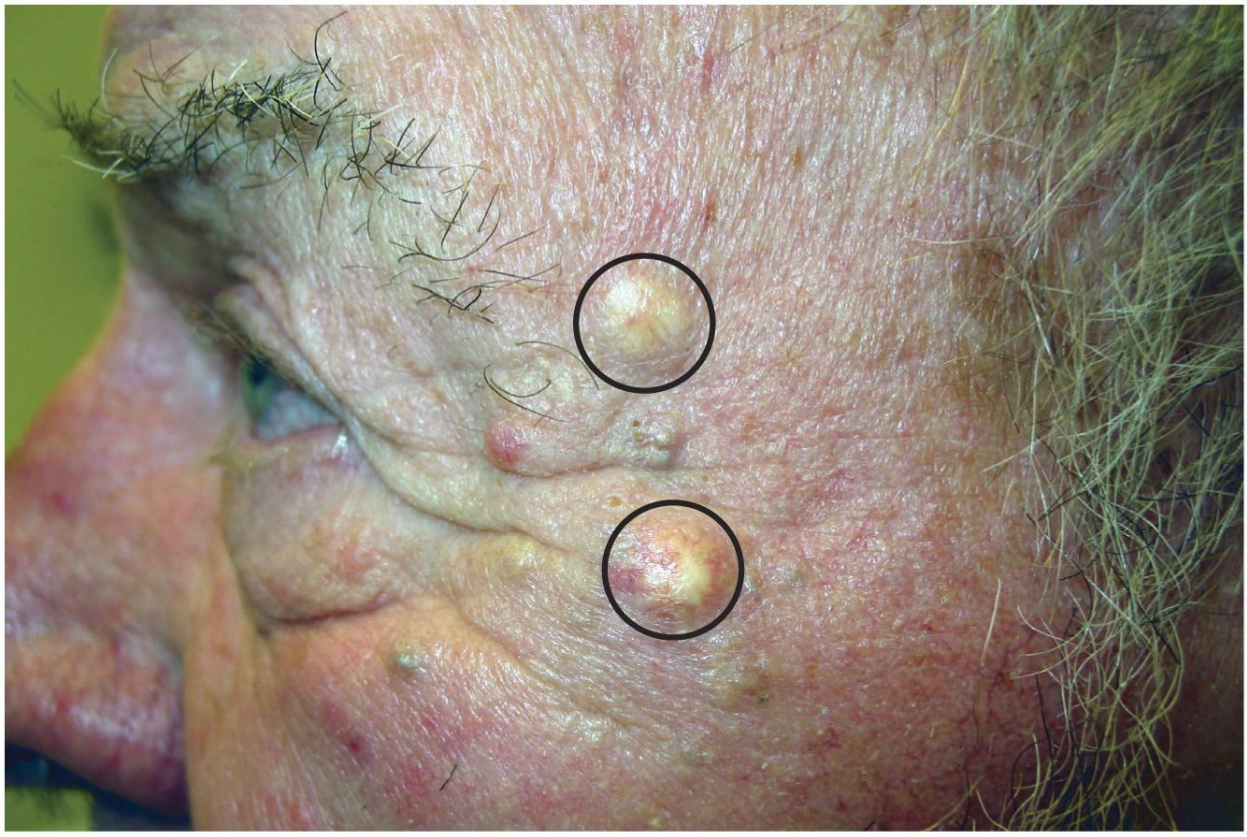

Vital Signs

Name FRASIER FAIRHALL

Date 2/05/XX

Temperature 98.2°F (36.77°C)

Pulse 80

Respiratory Rate 20

Blood Pressure 158/100

Tobacco Use: ☐ Never ☐ Former

☒ Cigarettes 3 packs/day ☐ Pipe ☐ Smokeless tobacco

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Smoking History

Patient FRASIER FAIRHALL Date 2/05/XX

1. At what age did you begin to smoke? 13

2. How many cigarettes do you smoke per day now? 3 PACKS
   Per day at your heaviest? 3 PACKS

3. How many times have you tried to stop smoking? 5
   ☐ Never tried to stop

4. What is the longest period of time you have gone without smoking? 5 DAYS

5. What forms of tobacco are you currently using? *(Please check all that apply.)*
   - ☒ Cigarettes
   - ☐ Pipes
   - ☐ Cigars
   - ☐ Chewing tobacco
   - ☐ Snuff
   - ☐ Other

6. Do your ☐ family members, ☒ friends, ☒ co-workers smoke? *(Please check all that apply. Circle if you live with any of these smokers.)*

7. What smoking cessation methods have you tried? *(Please check all that apply.)*
   - ☐ None
   - ☒ Cold turkey
   - ☐ Hypnosis
   - ☐ Acupuncture
   - ☐ Self-help programs
   - ☐ Gradual reduction
   - ☐ Laser
   - ☒ Other NICOTINE GUM

8. Are you being ☒ encouraged, or ☐ discouraged to stop smoking by any of the following? *(Please check all that apply.)*
   - ☐ Spouse or significant other
   - ☒ Child
   - ☐ Other family member
   - ☐ Friend
   - ☐ Co-worker

9. Who do you turn to for support? *(Please check all that apply.)*
   - ☒ Spouse or significant other
   - ☐ Parent
   - ☐ Sibling
   - ☒ Other family member
   - ☐ Clergy/rabbi/priest
   - ☐ Counselor
   - ☐ Healthcare provider
   - ☐ Friend
   - ☐ Co-worker

Please rank the following on a scale of 1 (strongly disagree) to 5 (strongly agree):

I am ready to stop smoking at this time:	1	(2)	3	4	5
I am concerned about weight gain:	(1)	2	3	4	5
I am concerned about dealing with stress:	1	2	3	4	(5)

Frasier Fairhall
Patient Signature

Esther Manheim, DHZ
Reviewed by

Medication List

Patient FRASIER FAIRHALL Date 2/05/XX

PRESCRIBED

NONE

OVER-THE-COUNTER

NYTOL SLEEPING PILL - ONE EACH NIGHT

VITAMINS, HERBS, DIET SUPPLEMENTS

NONE

MetLife

University of the Pacific

HEALTH HISTORY - English

Patient Name: Fairhall, Frasier F.

Patient Identification Number: F-345680

Birth Date: 57 years

I. CIRCLE APPROPRIATE ANSWER (leave BLANK if you do not understand question):

1. (Yes) No — Is your general health good?
2. Yes (No) — Has there been a change in your health within the last year?
3. Yes (No) — Have you been hospitalized or had a serious illness in the last three years?
   If YES, why? _____
4. Yes (No) — Are you being treated by a physician now? For what? _____
   Date of last medical exam? 10 years ago Date of last dental exam? 5 years
5. Yes (No) — Have you had problems with prior dental treatment?
6. Yes (No) — Are you in pain now?

II. HAVE YOU EXPERIENCED:

7.	Yes	(No)	Chest pain (angina)?	18.	Yes	(No)	Dizziness?
8.	Yes	(No)	Swollen ankles?	19.	Yes	(No)	Ringing in ears?
9.	Yes	(No)	Shortness of breath?	20.	Yes	(No)	Headaches?
10.	Yes	(No)	Recent weight loss, fever, night sweats?	21.	Yes	(No)	Fainting spells?
11.	Yes	(No)	Persistent cough, coughing up blood?	22.	Yes	(No)	Blurred vision?
12.	(Yes)	No	Bleeding problems, bruising easily? gums bleed when I brush	23.	Yes	(No)	Seizures?
13.	Yes	(No)	Sinus problems?	24.	Yes	(No)	Excessive thirst?
14.	Yes	(No)	Difficulty swallowing?	25.	Yes	(No)	Frequent urination?
15.	Yes	(No)	Diarrhea, constipation, blood in stools?	26.	(Yes)	No	Dry mouth?
16.	Yes	(No)	Frequent vomiting, nausea?	27.	Yes	(No)	Jaundice?
17.	Yes	(No)	Difficulty urinating, blood in urine?	28.	Yes	(No)	Joint pain?

III. DO YOU HAVE OR HAVE YOU HAD:

29.	Yes	(No)	Heart disease?	40.	Yes	(No)	AIDS?
30.	Yes	(No)	Heart attack, heart defects?	41.	Yes	(No)	Tumors, cancer?
31.	Yes	(No)	Heart murmurs?	42.	Yes	(No)	Arthritis, rheumatism?
32.	Yes	(No)	Rheumatic fever?	43.	Yes	(No)	Eye diseases?
33.	Yes	(No)	Stroke, hardening of arteries?	44.	Yes	(No)	Skin deases?
34.	Yes	(No)	High blood pressure?	45.	Yes	(No)	Anemia?
35.	Yes	(No)	Asthma, TB, emphysema, other lung disease?	46.	Yes	(No)	VD (syphilis or gonorrhea)?
36.	(Yes)	No	(Hepatitis), other liver disease? 2 years ago	47.	Yes	(No)	Herpes?
37.	Yes	(No)	Stomach problems, ulcers? Iodine, raweed,	48.	Yes	(No)	Kidney, bladder disease?
38.	(Yes)	No	Allergies to: drugs, foods, medications, latex? and cats	49.	Yes	(No)	Thyroid, adrenal disease?
39.	Yes	(No)	Family history of diabetes, heart problems, tumors?	50.	Yes	(No)	Diabetes?

IV. DO YOU HAVE OR HAVE YOU HAD:

51.	Yes	(No)	Psychiatric care?	56.	Yes	(No)	Hospitalization?
52.	Yes	(No)	Radiation treatments?	57.	Yes	(No)	Blood transfusions?
53.	Yes	(No)	Chemotherapy?	58.	Yes	(No)	Surgeries?
54.	Yes	(No)	Prosthetic heart valve?	59.	Yes	(No)	Pacemaker?
55.	Yes	(No)	Artificial joint?	60.	Yes	(No)	Contact lenses?

V. ARE YOU TAKING:

61.	Yes	(No)	Recreational drugs?	63.	(Yes)	No	Tobacco in any form? cigarettes, 3 packs/day
62.	(Yes)	No	Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies?	64.	(Yes)	No	Alcohol? 4 cocktails/day

Please list: See Medication List

VI. WOMEN ONLY:

65.	Yes	(No)	Are you or could you be pregnant or nursing?	63.	Yes	(No)	Taking birth control pills?

VII. ALL PATIENTS:

64. (Yes) No — Do you have or have you had anyother diseases or medical problems NOT listed on this form?

If so, please explain: have trouble sleeping; get sores in my mouth often

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient's signature: Frasier Fairhall Date: 1-15-20XX

RECALL REVIEW:

1. Patient's signature: _____ Date: _____
2. Patient's signature: _____ Date: _____
3. Patient's signature: _____ Date: _____

The Health History is created and maintined by the University of Pacific School of Dentistry, San Francisco, California.
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