

Patient Name _____

MEDICAL HISTORY

Patient Account No. _____

Medical Alert _____

1. Have you been under the care of a medical doctor during the past two years? Yes No

If yes, for what? _____

Physician's Name _____

Address _____ City _____ State _____ Zip _____

2. Have you taken any medication or drugs during the past two years? Yes No

3. Are you taking any medication, drugs or pills now, including regular dosages of aspirin? Yes No

If yes, please list name and dosage _____

4. Have you ever taken prescription medications for weight loss (diet pills)? Yes No

If yes, did you take any of the following: Yes No Fen-Phen (Fenfluramine-Phentermine)

Yes No Pondimin (Fenfluramine)

Yes No Redux (Desfenfluramine)

If yes to any of the above, did you have a medical exam for heart issues? Yes No

**5. Are you aware of having an allergic (or adverse) reaction to any medication or substance? Yes No

If yes, please list: _____

6. Have you been a patient in the hospital during the past five years? Yes No

7. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack) Yes No	Ulcers Yes No	Hepatitis A (infectious) B (serum) Yes No
Chest Pain Yes No	Diabetes Yes No	Venereal Disease Yes No
Congenital Heart Disease Yes No	Thyroid Problems Yes No	A.I.D.S. Yes No
Heart Murmur Yes No	Glaucoma Yes No	H.I.V. Positive Yes No
High Blood Pressure Yes No	Contact Lens Yes No	Cold Sores/Fever Blisters Yes No
Mitral Valve Prolapse Yes No	Emphysema Yes No	Blood Transfusion Yes No
Artificial Heart Valve Yes No	Chronic Cough Yes No	Hemophilia Yes No
Heart Pacemaker Yes No	Tuberculosis Yes No	Sickle Cell Disease Yes No
Rheumatic Fever Yes No	Asthma Yes No	Bruise Easily Yes No
Arthritis/Rheumatism Yes No	Hay Fever Yes No	Liver Disease Yes No
Cortisone Medicine Yes No	Latex Sensitivity Yes No	Yellow Jaundice Yes No
Swollen Ankles Yes No	Allergies or Hives Yes No	Neurological Disorders Yes No
Stroke Yes No	Sinus Trouble Yes No	Epilepsy or Seizures Yes No
Diet (Special/Restricted) Yes No	Radiation Therapy Yes No	Fainting or Dizzy Spells Yes No
Artificial Joints (hip, knee, etc.) .. Yes No	Chemotherapy Yes No	Nervous/Anxious Yes No
Kidney Trouble Yes No	Tumors Yes No	Psychiatric/Psychological Care .. Yes No

8. Do you use more than two pillows to sleep? Yes No

9. Have you lost or gained more than 10 pounds in the past year? Yes No

10. Do you have or have you had any disease, condition, or problem not listed? Yes No

If yes, please list: _____

11. Women. Are you: Pregnant? Yes, ___ Months No Nursing? Yes No Taking birth control pills? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health or medication.

Patient/Guardian Signature _____ Date _____

History Review	
Dentist Signature _____	Date _____