Medical history

Patient's name : _____

1. Are you under a physicians care? ☐ Yes ☐ No ☐ Dont Know
   Since when? _____ For What? _____
2. When was your last complete physical exam? ____/____/____
3. Physicians Name : _____
   Address : _____ City : _____ State : _____ Zip : _____
4. Are you taking any medication or substances? ☐ Yes ☐ No ☐ Dont Know
   Please list: _____

5. Do you routinely take health related substances?(vitamin, herbal supplements, natural products)? ☐ Yes ☐ No ☐ Dont Know
6. Are you allergic to any medications or substances? ☐ Yes ☐ No ☐ Dont Know
   Please list: _____

7. Do you have any other allergies or hives? ☐ Yes ☐ No ☐ Dont Know
8. Do you have any problems with penicillin, antibiotics, anesthetics or other medications? ☐ Yes ☐ No ☐ Dont Know
9. Are you sensitive to any metals or latex? ☐ Yes ☐ No ☐ Dont Know
10. Are you pregnant or suspect you may be? ☐ Yes ☐ No ☐ Dont Know
11. Do you use any birth control medications? ☐ Yes ☐ No ☐ Dont Know
12. Have you ever been treated for or been told you might have heart disease? ☐ Yes ☐ No ☐ Dont Know
13. Do you have a pacemaker, an artificial heart valve, implant or been diagnosed with mitral valve prolapse? ☐ Yes ☐ No ☐ Dont Know
14. Have you ever had rheumatic fever resulting in rheumatic heart disease? ☐ Yes ☐ No ☐ Dont Know
15. Are you aware of any heart murmurs? ☐ Yes ☐ No ☐ Dont Know
16. Do you have blood pressure problems? ☐ Yes ☐ No ☐ Dont Know
17. Have you ever had a serious illness or major surgery? ☐ Yes ☐ No ☐ Dont Know
    Please give details : _____

18. Have you ever had radiation treatment or chemotherapy for a tumor, growth or other condition? ☐ Yes ☐ No ☐ Dont Know
19. Do you have inflammatory diseases, such as arthritis or rheumatism? ☐ Yes ☐ No ☐ Dont Know
20. Do you have any artificial joints or prostheses? ☐ Yes ☐ No ☐ Dont Know
21. Do you have any blood disorders such as anemia, leukemia, etc.? ☐ Yes ☐ No ☐ Dont Know
22. Have you ever bled excessively after being cut or injured? ☐ Yes ☐ No ☐ Dont Know
23. Do you have any stomach problems? ☐ Yes ☐ No ☐ Dont Know
24. Do you have any kidney problems? ☐ Yes ☐ No ☐ Dont Know
25. Do you have any liver problems? ☐ Yes ☐ No ☐ Dont Know
26. Are you diabetic? ☐ Yes ☐ No ☐ Dont Know
27. Do you have fainting or dizzy spells? ☐ Yes ☐ No ☐ Dont Know
28. Do you have asthma? ☐ Yes ☐ No ☐ Dont Know
29. Do you have epilepsy or seizure disorders? ☐ Yes ☐ No ☐ Dont Know
30. Do you or have you ever had a venereal disease? ☐ Yes ☐ No ☐ Dont Know
31. Have you tested positive for HIV? ☐ Yes ☐ No ☐ Dont Know
32. Do you have AIDS? ☐ Yes ☐ No ☐ Dont Know
33. Have you had or do you test positive for Hepatitis? ☐ Yes ☐ No ☐ Dont Know
34. Do you or have you had Tuburculosis (TB)? ☐ Yes ☐ No ☐ Dont Know
35. Do you smoke, chew, use snuff or any other forms of tobacco? How much? _____ ☐ Yes ☐ No ☐ Dont Know
36. style="width:380pt;"Do you regularly consume more than one or two alcoholic beverages a day? ☐ Yes ☐ No ☐ Dont Know
37. Have you had psychiatric treatment? ☐ Yes ☐ No ☐ Dont Know
38. Do you habitually use controlled substances, legal or illegal? ☐ Yes ☐ No ☐ Dont Know
39. Have you taken any of the following? Fenfluramine, fenfluramine combined with phentermine (fen-phen), Dexfenfluramine (redux), or other weight loss products? ☐ Yes ☐ No ☐ Dont Know

40. Do you have any disease condition, or problem not listed? ☐ Yes ☐ No ☐ Dont Know

If so list : _____

41. Is there anything else we should know about your health that we have not covered in this form?

42. Would you like to speak to the Doctor privately about any problem? ☐ Yes ☐ No ☐ Dont Know

☐ I certify that the above information is complete and accurate.

Patient's / Guardian's signature : _____ Date : _____

Dentist's Signature : _____ Date : _____