

MEDICAL HISTORY

NAME _____ D.O.B. _____ DATE _____

1. Are you having pain or discomfort at this time? YES NO
2. Have you been a patient in the hospital during the past two years? YES NO
3. Have you been under the care of a medical doctor during the past two years? YES NO

Physician's Name _____ Phone No. _____

Last Physical Examination _____

4. Have you taken any medication or drugs during the past two years? YES NO
If yes Please List _____
5. Are you now taking any medication, herbal supplements and / or vitamins? YES NO
If yes Please List _____
6. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? YES NO
If yes Please List _____

7. Indicate which of the following you have had or have at present circle "YES or NO" to each item.

Heart Failure.....	YES NO	Artificial Joints(Hip,knee,etc.)	YES NO	Hepatitis (type_____)	YES NO
Heart Disease or Attack.....	YES NO	Kidney Trouble	YES NO	Venereal Disease.....	YES NO
Angina Pectoris.....	YES NO	Ulcer.....	YES NO	A.I.D.S. / H.I.V.....	YES NO
Congenital Heart Disease.....	YES NO	Diabetes.....	YES NO	Head or Neck Injuries.....	YES NO
Heart Murmur.....	YES NO	Thyroid Problems.....	YES NO	Cold sores / Fever Blisters.....	YES NO
High Blood Pressure.....	YES NO	Glaucoma	YES NO	Blood Transfusion.....	YES NO
Arteriosclorosis.....	YES NO	Cosmetic Surgery.....	YES NO	Hemophilia	YES NO
Mitral Valve Prolapse.....	YES NO	Emphysema	YES NO	Prolonged Bleeding due to cut....	YES NO
Artificial Heart Valve.....	YES NO	Chronic Cough	YES NO	Anemia.....	YES NO
Heart Pacemaker.....	YES NO	Tuberculosis.....	YES NO	Sickle Cell Disease.....	YES NO
Heart Surgery.....	YES NO	Asthma	YES NO	Bruise Easily.....	YES NO
Rheumatic Fever.....	YES NO	Hay Fever	YES NO	Liver Disease.....	YES NO
Arthritis.....	YES NO	Allergies or Hives	YES NO	Yellow Jaundice.....	YES NO
Rheumatism	YES NO	Sinus Trouble	YES NO	Epilepsy or Seizures.....	YES NO
Cortisone Medicine.....	YES NO	Radiation Therapy.....	YES NO	Fainting or Dizzy Spells.....	YES NO
Drug Addiction	YES NO	Chemotherapy.....	YES NO	Nervousness.....	YES NO
Stroke	YES NO	Digestive Disorders.....	YES NO	Psychiatric Treatment.....	YES NO

8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest.
shortness of breath or because you are very tired? YES NO
9. Do your ankles swell during the day? YES NO
10. Do you use more than two pillows to sleep? YES NO
11. Have you lost or gained more than 10 pounds in the past year? YES NO
12. Do you ever wake up from sleep and feel short of breath? YES NO
13. Are you on a special diet? YES NO
14. Has your medical doctor ever said you have cancer or tumor? YES NO
15. Do you have or have you had any disease, condition, or problem not listed? YES NO
16. Have you ever taken prescription medication for weight reduction (DIET PILLS)? YES NO
If "YES" DID YOU take any of the below listed drugs? (Please indicate with an X on line.)
____Fen-Phen (fenfluramine-phentermine) ____Pondimin (fenfluramine) ____Redux (dexfenfluramine)
If you have ever taken any of the above drugs, have you had a medical exam to insure that
your heart valves were not effected? YES NO

17. FOR WOMEN ONLY

- Are you pregnant? YES - WHAT MONTH?_____ NO
- Are you nursing?
- Are you taking birth control pills?

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature _____ Date _____