Patient Name

MEDICAL HISTORY

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_____Phone_____
   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 Pondimen (Fenfluramine)
   Yes No Redux (Dexfenfluramine)
   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 Lenses ……..... 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 be 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_____