MEDICAL HISTORY

(name)	(medical alert)

1. Have you been under the care of a medical doctor during the past 2 years?_______________ Yes/No
   If yes, for what?_______________
   Physician's Name_______________ Address_______________
   City_______________ State_______________ Zip_______________ Phone #_______________
2. Have you taken any medication or drugs within the past 2 years?_______________ Yes/No
3. Are you taking any medication, drugs or pills now, including regular dose 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? Fen-Phen (Fenfluramine-Phentermine)_______________ Yes/No
   Pondimen (Fenfluramine)_______________ Yes/No
   Redux (Dexfenfluramine)_______________ Yes/No
   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 in the past 5 years?_______________ Yes/No
7. Indicate which of the following you have had, or have at the present. **Please circle "yes" or "no" to each item**.

Heart (surgery, disease, attack)	yes/no	Ulcers	yes/no	Hepatitis A, B or C	yes/no
Chest pain	yes/no	Diabetes	yes/no	Venereal Disease	yes/no
Congenital Heart Disease	yes/no	Thyroid Problems	yes/no	AIDS/HIV+	yes/no
Heart Murmur	yes/no	Glaucoma	yes/no	Cold Sores/Fever Blisters	yes/no
High Blood Pressure	yes/no	Contact Lenses	yes/no	Blood Transfusion	yes/no
Mitral Valve Prolapse	yes/no	Emphysema	yes/no	Hemophilia	yes/no
Artificial Heart Valve	yes/no	Chronic Cough	yes/no	Sickle Cell Disease	yes/no
Heart Pacemaker	yes/no	Tuberculosis	yes/no	Bruise Easily	yes/no
Rheumatic Fever	yes/no	Asthma	yes/no	Liver Disease	yes/no
Arthritis/Rheumatism	yes/no	Hay Fever	yes/no	Yellow Jaundice	yes/no
Cortisone Medicine	yes/no	Latex Sensitivity	yes/no	Neurological Disorders	yes/no
Swollen Ankles	yes/no	Allergies or Hives	yes/no	Epilepsy or Seizures	yes/no
Stroke	yes/no	Sinus Trouble	yes/no	Fainting or Dizzy Spells	yes/no
Diet (Special/Restricted)	yes/no	Radiation Therapy	yes/no	Nervous/Anxious	yes/no
Artificial Joints (hip, knee, etc.)	yes/no	Chemotherapy	yes/no	Psychiatric/Psychological Care	yes/no
Kidney Trouble/Dialysis	yes/no	Tumors	yes/no	Cigarettes/Tobacco Use	yes/no

8. Do you use more than 2 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, medical 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 and/or medication(s).

Patient/Guardian Signature_______________ Date_______________

Medical History Review

Dentist Signature_______________ Date_______________