Submit by Email | Print Form

**PATIENT NAME**_____
Last First Initial Date of Birth

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

1. Physician's Name

   Address_____
2. Are you now under a physician's care for a particular problem? YES ☐ NO ☐

   Since when_____ Why_____
3. When was your last complete Physical exam?_____
4. When was your last complete Dental exam? _____
5. Are you currently taking any medications? ..... YES ☐ NO ☐
   (If yes, please list medications in the Comments column.)
6. Do you routinely take health related substances? ..... YES ☐ NO ☐
7. Are you allergic to any medication or substances? Or have any other allergies? ..... YES ☐ NO ☐
8. Are you currently or have history of taking Bisphosphonate? ..... YES ☐ NO ☐
   Actinel C ☐ Fosamax ☐ Didronel ☐ Boniva ☐ Skelid ☐
9. Do you have any problems with penicillin, antibiotics, anesthetics, or other medications? ..... YES ☐ NO ☐
10. Are you sensitive to any metals or latex? ..... YES ☐ NO ☐
11. Are you pregnant or suspect you may be? ..... YES ☐ NO ☐
12. Do you use any birth control medications? ..... YES ☐ NO ☐
13. Have you ever been treated for or been told you might have heart disease? ..... YES ☐ NO ☐
14. Do you have a pacemaker or an artificial heart valve implant? ..... YES ☐ NO ☐
15. Have you ever had rheumatic fever? ..... YES ☐ NO ☐
16. Are you aware of any heart murmurs? ..... YES ☐ NO ☐
17. Do you have high or low blood pressure? ..... YES ☐ NO ☐
18. Have you ever had a serious illness or major surgery? ..... YES ☐ NO ☐

    If so, explain_____
19. Do you have inflammatory diseases, such as arthritis or rheumatism? ..... YES ☐ NO ☐
20. Do you have any artificial joints / prosthesis? ..... YES ☐ NO ☐
21. Do you have any blood disorders, such as anemia, leukemia, etc.?..... YES ☐ NO ☐
22. Have you ever bleed excessively after being cut or injured? ..... YES ☐ NO ☐
23. Do you have any stomach problems? ..... YES ☐ NO ☐
24. Do you have any kidney problems? ..... YES ☐ NO ☐
25. Do you have any liver problems? ..... YES ☐ NO ☐
26. Are you diabetic? ..... YES ☐ NO ☐
27. Do you have asthma? ..... YES ☐ NO ☐
28. Do you have epilepsy or seizure disorders? ..... YES ☐ NO ☐
29. Do you have or ever had a venereal disease? ..... YES ☐ NO ☐
30. Have you ever tested HIV positive? ..... YES ☐ NO ☐
31. Do you have AIDS? ..... YES ☐ NO ☐
32. Have you had or do you test positive for hepatitis? ..... YES ☐ NO ☐
33. Do you or have you had T.B.?..... YES ☐ NO ☐
34. Do you smoke, chew, use snuff or any other form of tobacco? ..... YES ☐ NO ☐
35. Do you consume alcoholic beverages? ..... YES ☐ NO ☐
36. Do you habitually use controlled substances? ..... YES ☐ NO ☐
37. Have you had psychiatric treatment? ..... YES ☐ NO ☐
38. Have you taken the prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenflurmin (redux), or other weight loss products? ..... YES ☐ NO ☐
39. Do you have any disease, condition or problem not listed? ..... YES ☐ NO ☐

    If so, explain_____
40. Is there anything else we should know about your health that we have not covered in this form

    _____
41. Would you like to speak to the Doctor privately about any problem? ..... YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT / GUARDIAN'S SIGNATURE_____ DATE_____

DENTIST'S SIGNATURE_____ DATE_____

ANEST.

MED. ALERT

# MEDICAL HISTORY