MEDICAL HISTORY

Patient Name
Medical Alert

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. Are you taking any medication, drugs or pills now, including regular dosages of aspirin? ---------- **YES** ◯ **NO** ◯
   If yes, please list name and dosage _____
3. Have you ever taken prescription medications for weight loss (diet pills)? ---------- **YES** ◯ **NO** ◯
   If yes, did you take 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** ◯
4. Are you aware of having an allergic **(or adverse)** reaction to any medication or substance? ---------- **YES** ◯ **NO** ◯
   If yes, please explain. _____
5. Have you been a patient in the hospital during the past five years? ---------- **YES** ◯ **NO** ◯
   If yes, please explain._____
6. 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, B, or other --	**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** ◯
Stroke ----------	**YES** ◯ **NO** ◯	Allergies/Hives -	**YES** ◯ **NO** ◯	Neurological Disorders --	**YES** ◯ **NO** ◯
Diet (Special/Restricted) --------	**YES** ◯ **NO** ◯	Sinus Trouble ---	**YES** ◯ **NO** ◯	Epilepsy or Seizures -----	**YES** ◯ **NO** ◯
Artificial Joints ----------	**YES** ◯ **NO** ◯	Radiation Therapy	**YES** ◯ **NO** ◯	Fainting or Dizzy Spells -	**YES** ◯ **NO** ◯
Kidney Trouble ----------	**YES** ◯ **NO** ◯	Chemotherapy --	**YES** ◯ **NO** ◯	Nervous/Anxious ---------	**YES** ◯ **NO** ◯
Psychiatric/Psychological Care	**YES** ◯ **NO** ◯	Tumors ----------	**YES** ◯ **NO** ◯		

7. Do you use more than two pillows to sleep? ---------- **YES** ◯ **NO** ◯
8. Have you lost or gained more than 10 pounds in the past year? ---------- **YES** ◯ **NO** ◯
9. Do you have or have you had any disease, condition, or problem not listed? ---------- **YES** ◯ **NO** ◯
   If yes, please list: _____
10. **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 or medication.

Patient/Guardian Signature _____Date _____

History Review

Dentist Signature _____ Date _____