Patient Name : _____

MEDICAL HISTORY

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 _____

Have you taken any medication or drugs during the past two years? ……..…… yes no

Are you taking any prescription, over the counter or recreational drugs now? ……..…… yes no

If yes, please list name and dosage _____

Have you ever taken any of the following weight loss medications:

Fen-phen (Fenfluramine-phenpermine) ……..…… yes no

Pondimen (Fendluramine) ……..…… yes no

Redux (Dexfesfluramine) ……..…… yes no

If yes, did you have a medical exam for heart issues? ……..…… yes no

Are you aware of having any allergic or adverse reactions to any medication or substance? ……..…….. yes no

If yes, please list _____

Have you been a patient in the hospital during the past five years? ……..…….. yes no

If yes, please explain _____

Circle any of the following you have had or have at present.

Heart (surgery, disease, attack)	Ulcers	Hepatitis A or B
Chest Pain	Diabetes	Venereal Disease
Congenital Heart Disease	Thyroid Problems	A.I.D.S.
Heart Murmur	Glaucoma	H.I.V. Positive
High Blood Pressure	Contact Lenses	Cold Sores/Fever Blisters
Mitral Valve Prolapse	Emphysema	Blood Transfusion
Artificial Heart Valve	Asthma	Hemophilia
Heart Pacemaker	Tuberculosis	Sickle Cell Disease
Rheumatic Fever	Yellow Jaundice	Psychiatric/Psychological Care
Arthritis/Rheumatism	Liver Disease	Nervous/Anxious
Cortisone Medicine	Kidney Trouble	Latex Sensitivity or Allergy
Swollen Ankles	Allergies or Hives	Neurological Disorders
Stroke	Sinus Trouble	Epilepsy or Seizures
Artificial Joint (hip, knee, etc.)	Radiation/Chemo Therapy	Fainting or Dizzy Spells

Do you have or have you had any disease, condition or problem not listed? …… yes no

If yes, please list _____

For 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 the 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 changes in my health or medication.

Patient/Guardian Signature _____ Date _____

Dentist Signature _____ Date _____