Patient Name	MEDICAL HISTORY
Patient Account No.	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. Have you taken any medication of drugs the past two years? ..... Yes ○ No ○
3. Are you taking any medication, drug or pills now? ..... 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-Phenopermine)
   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 of 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 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 _____