| 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 or drugs during the past two years? ..... Yes No
3. Are you taking any medication or drugs currently, including regular doses of aspirin or over-the-counter herbal medicines? ..... Yes No
   If yes, please list name and dosage _____
4. Have you ever taken any prescription drugs for weight loss, including Fen-Phen (fenfluramine-phentermine); Pondimen (fenfluramine); and Redux (dexfenfluramine)? ..... Yes No
   If yes to 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 B C (circle) | 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 or 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 or think you may be pregnant? Yes, ____ Months No **Nursing**? Yes No
12. **Women:** Do you use birth control medications? ..... 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 dentist of any changes in my health or medication.*

Patient/Guardian Signature _____ Date _____

**History Review**

Dentist Signature _____ Date _____

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