Patient Name	MEDICAL HISTORY
Patient Account #	Medical Alert

1. Have you been under the care of a medical doctor within the past two years? ..... Yes No
   If yes, for what? _____
   Physician's Name _____ Phone _____
   Address _____ City _____ State _____ Zip _____
2. Have you taken any medications over the past two years? ..... Yes No
3. Are you taking any medications, drugs, 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-Phenpermine)
   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. Please indicate which of the following you have had, or have at present. Circle "yes" or "no" for each item listed below.

Heart (surgery, attack, disease) ..... Yes No	Ulcers ..... Yes No	Hepatitis A, B, C ..... Yes No
Chest pain ..... Yes No	Diabetes ..... Yes No	Venereal Disease ..... Yes No
Congenital Heart Disease ..... Yes No	Thyroid Problem ..... Yes No	AIDS ..... Yes No
Heart Murmur ..... Yes No	Glaucoma ..... Yes No	HIV 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 Medication ..... 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. Have you ever had a reaction to any type of jewelry ..... 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: _____ Yes No
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 _____