

PATIENT NAME	How should we address you?
MEDICAL ALERT	

# MEDICAL HISTORY

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, 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: Fen-Phen (Fenfluramine-Phenpermine)  Yes  No

Pondimin (Fenfluramine)  Yes  No

Redux (Dexfenfluramine)  Yes  No

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

6. Have you been a patient in the hospital during the past five years?  Yes  No

7. Indicate which or the following you have had, or have at present. Circle "yes" or "no" to each item.

- |                                                                                            |                                                                             |                                                                                         |
|--------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|
| Heart (Surgery, Disease, Attack) <input type="checkbox"/> Yes <input type="checkbox"/> No  | Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No             | Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No                      |
| Chest Pain <input type="checkbox"/> Yes <input type="checkbox"/> No                        | Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No           | Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No               |
| Congenital Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No          | Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No   | A.I.D.S. <input type="checkbox"/> Yes <input type="checkbox"/> No                       |
| Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No                      | Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No           | H.I.V. Positive <input type="checkbox"/> Yes <input type="checkbox"/> No                |
| High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No               | Contact lenses <input type="checkbox"/> Yes <input type="checkbox"/> No     | Cold Sores/Fever Blisters <input type="checkbox"/> Yes <input type="checkbox"/> No      |
| Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No             | Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No          | Blood Transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No              |
| Artificial Heart Valve <input type="checkbox"/> Yes <input type="checkbox"/> No            | Chronic Cough <input type="checkbox"/> Yes <input type="checkbox"/> No      | Hemophilia <input type="checkbox"/> Yes <input type="checkbox"/> No                     |
| Heart Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No                   | Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No       | Sickle Cell Disease <input type="checkbox"/> Yes <input type="checkbox"/> No            |
| Rheumatic fever <input type="checkbox"/> Yes <input type="checkbox"/> No                   | Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No             | Bruise Easily <input type="checkbox"/> Yes <input type="checkbox"/> No                  |
| Arthritis/Rheumatism <input type="checkbox"/> Yes <input type="checkbox"/> No              | Hay Fever <input type="checkbox"/> Yes <input type="checkbox"/> No          | Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No                  |
| Coetisone Medicine <input type="checkbox"/> Yes <input type="checkbox"/> No                | Latex Sensitivity <input type="checkbox"/> Yes <input type="checkbox"/> No  | Yellow Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No                |
| Swollen Ankles <input type="checkbox"/> Yes <input type="checkbox"/> No                    | Allergies or Hives <input type="checkbox"/> Yes <input type="checkbox"/> No | Neurological Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No         |
| Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No                            | Sinus Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No      | Epilepsy or Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No           |
| Diet (Special/Restricted) <input type="checkbox"/> Yes <input type="checkbox"/> No         | Radiation Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No  | Fainting or Dizzy Spells <input type="checkbox"/> Yes <input type="checkbox"/> No       |
| Artificial Joints (hip,knee,etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No | Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No       | Nervous/Anxious <input type="checkbox"/> Yes <input type="checkbox"/> No                |
| Kidney Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No                    | Tumors <input type="checkbox"/> Yes <input type="checkbox"/> No             | Psychiatric/Psychological Care <input type="checkbox"/> Yes <input type="checkbox"/> No |

8. Do you smoke? If so, how much?.....  Yes  No

9. Have you had abnormal bleeding associated with extractions, surgery, injury or menstruation?  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 any change in my health or medication.

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**History Review:**

D.D.S. Signature: \_\_\_\_\_ Date: \_\_\_\_\_