

Patient's Name \_\_\_\_\_  
Last First Initial Date of Birth

Circle the appropriate answer, if you do don't know the correct answer please write down COMMENTS

" don't know " on the line after the question.

- 1. Physician's Name \_\_\_\_\_ Address \_\_\_\_\_
- 2. Are you under a Physician's care? ..... Yes No  
Since when \_\_\_\_\_ Why \_\_\_\_\_
- 3. When was your last complete physical exam? \_\_\_\_\_
- 4. Are you taking any medication or substance? ..... Yes No  
( if yes, please list medications in comments section or no the back of this form.)
- 5. Do you routinely take health related substance? ..... Yes No
- 6. Are you allergic to any medication or substance? (please list) ..... Yes No
- 7. Do you have any other allergies or hives? ..... Yes No
- 8. Do you have any problems with penicillin, antibiotics, anesthetics or other medications? ..... Yes No
- 9. Are you sensitive to metals or latex? ..... Yes No
- 10. Are you pregnant or suspect you may be? ..... Yes No
- 11. Do you use any birth control medications? ..... Yes No
- 12. Have you ever been treated for or been told you might have heart disease? ..... Yes No
- 13. Do you have a pacemaker or any artificial heart valve implant? ..... Yes No
- 14. Have you ever had rheumatic fever? ..... Yes No
- 15. Are you aware of any heart murmurs? ..... Yes No
- 16. Do you have high or low blood pressure? (please circle) ..... Yes No
- 17. Have you ever had a serious illness or major surgery? ..... Yes No  
If so, explain \_\_\_\_\_
- 18. Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition? ..... Yes No
- 19. Do you have inflammatory disease, such as arthritis or rheumatism? ..... Yes No
- 20. Do you have any artificial joints/prosthesis? ..... Yes No
- 21. Do you have any blood disorders, such as anemia, leukemia, etc? ..... Yes No
- 22. Have you ever bled excessively after being cut or injured? ..... Yes No
- 23. Do you have any stomach problems? ..... Yes No
- 24. Do you any kidney problems? ..... Yes No
- 25. Do you have any liver problems? ..... Yes No
- 26. Are you diabetic? ..... Yes No
- 27. Do you have fainting or dizzy spells? ..... Yes No
- 28. Do you have asthma? ..... Yes No
- 29. Do you have epilepsy or seizure disorders? ..... Yes No
- 30. Do you or have you had venereal disease? ..... Yes No
- 32. Have you tested HIV positive? ..... Yes No
- 33. Have you had or do you test positive for hepatitis? ..... Yes No
- 34. Do you or have you had T.B.? ..... Yes No
- 35. Do you smoke, chew, use snuff or any other forms of tobacco? ..... Yes No
- 36. Do you consume alcoholic beverages? ..... Yes No
- 37. Do you habitually use controlled substances? ..... Yes No
- 38. Have you had psychiatric treatment? ..... Yes No
- 39. Have you taken any prescription drug Fenfluramine, fenfluramine combine with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products? ..... Yes No
- 40. Do you have any disease condition, or problem not listed?. If so, explain \_\_\_\_\_

41. Is there anything else we should know about your health that we have not covered I this form? \_\_\_\_\_

42. Would you like to speak to the Doctor privately about any problem? ..... Yes No

I CERTIFY THAT ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S/ GUARDIAN'S SIGNATURE \_\_\_\_\_ Date \_\_\_\_\_  
DENTIST'S SIGNATURE \_\_\_\_\_ Date \_\_\_\_\_

**MEDICAL  
HISTORY**