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
   Pondimen (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)	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No	Hepatitis	☐ 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
Coetisone 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 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: ____________________