MEDICAL HISTORY

Please take a moment to let us know about your medical & dental history so we may provide you with the best possible care. All information is confidential.

PHYSICIAN'S NAME	PHONE #

1.) Have you had any medical care within the past two years?.. YES NO

Describe ____

2.) Have you taken any medication or drugs during the past two years?... YES NO

3.) Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosage of aspirin?.. YES NO

If yes, please list names and dosage ____

What pharmacy do you use (name, city, phone #)? ____________________________________

4.) Have you ever taken prescription medications for weight loss (diet pills)?..................................... YES NO

If yes, did you take any of the following? **CIRCLE ALL THAT APPLIES:**

Fen-Phen | Pondimen | Redux | Other

If yes to any of the following above did you have a medical exam for heart issues?...................... YES NO

5.) Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs?... YES NO

6.) Are you aware of having an allergic (or adverse) reaction to any substance or medication.......... YES NO

If yes, please specify ____

7.) Have you been a patient in the hospital during the past five years?.. YES NO

8.) Indicate which of the following you have had, or have present. **Circle “Yes” or “No” to each item**

Condition			Condition			Condition		
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
Congential Heart Disease....................	YES	NO	Thyroid Problems.	YES	NO	A.I.D.S. / H.I.V. Positive.........	YES	NO
Heart Murmur....................................	YES	NO	Glaucoma...............	YES	NO	Cold Sores/Fever Blisters.......	YES	NO
Low Blood Pressure........................	YES	NO	Contact Lenses....	YES	NO	Blood Transfusion................	YES	NO
High Blood Pressure........................	YES	NO	Emphysema...........	YES	NO	Hemophilia..........................	YES	NO
Mitral Valve Prolapse..........................	YES	NO	Chronic Cough......	YES	NO	Sickle Cell Disease................	YES	NO
Artificial Heart Valve/Pacemaker...........	YES	NO	Tuberculosis..........	YES	NO	Bruise Easily........................	YES	NO
Rheumatic Fever...............................	YES	NO	Asthma....................	YES	NO	Liver Disease/......................	YES	NO
Arthritis/Rheumatism..........................	YES	NO	Hay Fever...............	YES	NO	Yellow Jaundice....................	YES	NO
Cortisone Medicine............................	YES	NO	Allergy/Hives..........	YES	NO	Neurological Disorders...........	YES	NO
Swollen Ankles..................................	YES	NO	Latex Sensitivity....	YES	NO	Epilepsy/Seizures..................	YES	NO
Stroke..	YES	NO	Sinus Trouble.........	YES	NO	Fainting/Dizzy Spells.............	YES	NO
Diet (Special/Restricted).....................	YES	NO	Radiation Therapy.	YES	NO	Nervous/Anxious....................	YES	NO
Artificial Joints (Hip, Knee, etc.)............	YES	NO	Chemotherapy.......	YES	NO	Psychiatric Care...................	YES	NO
Kidney Trouble..................................	YES	NO	Tumors....................	YES	NO	Psychologial Care.................	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 NO

If yes, How many months?_____ Are you nursing?.. YES NO

12.) Do you use birth control prescriptions?... YES NO

If yes, I understand antibiotics may interfere with birth control pills and that other contraceptive methods should be used while taking antibiotics. (Please initial): _______.

I understand the above information is necessary to provide me wth 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___________