MEDICAL HISTORY

Patient Name :_____ Date of Birth_____ Age ____

Circle yes OR no for each question

1. Physician's Name _____ Phone ( ) _____
   Have you had any medical care in within the past two years?..... Yes No
   Describe_____
2. Have you taken any medication or drugs within the past two years? _____ Yes No
3. Are you taking ANY medication (prescription or over the counter), herbal remedies, including aspirin?..... Yes No
   If yes, please list (or provide list to be copied) _____
   _____
   _____
4. Have you ever taken prescription medications for weight loss (diet pills)?..... Yes No
   If yes, please circle which medication…… Fen-Phen Pondimen Redux Other
   If yes to any of the above, did you have a medical exam for heart issues?..... Yes No
5. Have you ever taken bone loss prevention drugs such as Fosamax, Boniva, Actonel or other similar drugs? Yes No
   If yes, how long did you take it for?_____
6. Are you aware of having an allergic (or adverse) reaction to any substance or medication? …… Yes No
   If yes, please list _____
7. Have you been a hospital patient in the past five years? (If yes, why?)…… Yes No
8. Have you ever had or do you presently have any of the following

Heart(Surgery,Disease,Attack)……	Yes	No	Ulcers……	Yes	No	Hepatitis A B C (circle)…….	Yes	No
Chest Pain……	Yes	No	Diabetes……	Yes	No	A.I.D.S/H.I.V Positive……	Yes	No
Congenital Heart Disease……	Yes	No	Thyroid Problems……	Yes	No	Liver Disease/Yellow Jaundice…	Yes	No
Heart Murmur……	Yes	No	Glaucoma…… ……	Yes	No	Cold Sores/Fever Blisters…..	Yes	No
High / Low Blood Pressure……	Yes	No	Sinus Trouble……	Yes	No	Blood Transfusion……	Yes	No
Mitral Valve Prolapse……	Yes	No	Emphysema……	Yes	No	Hemophilia……	Yes	No
Artificial Heart Valve/Pacemaker……	Yes	No	Tuberculosis……	Yes	No	Sickle Cell Disease……	Yes	No
Rheumatic Fever……	Yes	No	Fainting or Dizzy Spells……	Yes	No	Bruise Easily……	Yes	No
Arthritis/Rheumatism……	Yes	No	Asthma……	Yes	No	Neurological Disorders……	Yes	No
Cortisone Medication……	Yes	No	Hay Fever/Allergy/Hives…..	Yes	No	Epilepsy or Seizures……	Yes	No
Swollen Ankles……	Yes	No	Latex Sensitivity……	Yes	No	Nervous/Anxious……	Yes	No
Stroke……	Yes	No	Radiation Therapy……	Yes	No	Psychiatric/Psychological Care..	Yes	No
Diet (Special/Restricted)……	Yes	No	Chemotherapy……	Yes	No	Kidney Trouble……	Yes	No
Artificial Joints (hip,knee etc)……	Yes	No	Tumors……	Yes	No			

9. Have you lost or gained more than 10 pounds in the past year?..... Yes No
10. Do you have any other disease, condition or problem not listed?..... Yes No
    If yes, please list:_____
11. **Women** : Are you pregnant or think you could be pregnant? Yes _____ months No **Nursing**? Yes No
12. Do you use birth control prescriptions?..... 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 the 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 _____

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HISTORY REVIEW

Reviewed by Dr Georgeu_____ Date_____