



Patient Name _____ Date ____/____/____

Have you been under the care of a medical doctor during the last two years? Yes No

If so, for what reason(s)? _____

Physician's Name _____ Phone _____

City _____ State _____ Zip _____

Have you been a patient in the hospital during the past five years? _____

Are you currently taking any medications or drugs, including regular doses of aspirin or over the counter herbal medicines? _____ If so, please list name and dosage _____

Have you ever taken any prescription drugs for weight loss, including Fen-Phen, Podimen, or Redux? _____

If so, did you have a medical exam for heart issues? Yes No

Have you ever had an allergic reaction or adverse reaction to any medication or substance? Yes No

If so, please list _____

Indicate which of the following you have had, or have at present. (Please check all that apply)

- Heart disease, surgery, or attack
- Chest pain
- Congenital heart disease
- Heart murmur
- High blood pressure
- Mitral valve prolapse
- Heart pacemaker
- Rheumatic fever
- Arthritis / Rheumatism
- Cortisone medicine
- Stroke
- Diet (special / restricted)
- Artificial joints (hip, knee, etc)
- Kidney trouble
- Ulcers
- Diabetes
- Thyroid problems
- Glaucoma
- Contact lenses
- Emphysema
- Tuberculosis
- Asthma
- Hay fever
- Latex sensitivity
- Allergies or hives
- Sinus trouble
- Radiation therapy
- Tumors
- Hepatitis A B C
- Venereal disease
- A.I.D.S.
- H.I.V. positive
- Cold sores / fever blisters
- Blood transfusion
- Hemophilia
- Sickle cell disease
- Liver disease
- Yellow jaundice
- Neurological disorders
- Epilepsy or seizures
- Fainting or dizzy spells
- Psychiatric/Psychological care

Please list any disease, condition or problem not listed above: _____

Women: Are you pregnant? Yes No If so, _____ months. Nursing? Yes No

Do you use birth control medications? 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 dentist of any changes in my health or medications.

Patient / Guardian Signature

Date