

PATIENT

► Your Name (Patient's Name): _____ Date of last visit: _____

MEDICAL HISTORY

► Physician's Name: _____ Date of last visit: _____

► Have you ever been diagnosed with or experienced the following conditions?

AIDS/HIV	<input type="checkbox"/> Y	<input type="checkbox"/> N	Glaucoma	<input type="checkbox"/> Y	<input type="checkbox"/> N	Shortness of breath	<input type="checkbox"/> Y	<input type="checkbox"/> N
Anemia	<input type="checkbox"/> Y	<input type="checkbox"/> N	Headaches	<input type="checkbox"/> Y	<input type="checkbox"/> N	Sinus trouble	<input type="checkbox"/> Y	<input type="checkbox"/> N
Arthritis, Rheumatism	<input type="checkbox"/> Y	<input type="checkbox"/> N	Heart murmur	<input type="checkbox"/> Y	<input type="checkbox"/> N	Skin rash	<input type="checkbox"/> Y	<input type="checkbox"/> N
Artificial heart valves	<input type="checkbox"/> Y	<input type="checkbox"/> N	Heart problems	<input type="checkbox"/> Y	<input type="checkbox"/> N	Special diet	<input type="checkbox"/> Y	<input type="checkbox"/> N
Artificial joints	<input type="checkbox"/> Y	<input type="checkbox"/> N	Hepatitis Type _____	<input type="checkbox"/> Y	<input type="checkbox"/> N	Stroke	<input type="checkbox"/> Y	<input type="checkbox"/> N
Asthma	<input type="checkbox"/> Y	<input type="checkbox"/> N	Herpes	<input type="checkbox"/> Y	<input type="checkbox"/> N	Swollen feet or ankles	<input type="checkbox"/> Y	<input type="checkbox"/> N
Back problems	<input type="checkbox"/> Y	<input type="checkbox"/> N	High blood pressure	<input type="checkbox"/> Y	<input type="checkbox"/> N	Swollen neck glands	<input type="checkbox"/> Y	<input type="checkbox"/> N
Bleeds abnormally	<input type="checkbox"/> Y	<input type="checkbox"/> N	Jaundice	<input type="checkbox"/> Y	<input type="checkbox"/> N	Thyroid problems	<input type="checkbox"/> Y	<input type="checkbox"/> N
Blood disease	<input type="checkbox"/> Y	<input type="checkbox"/> N	Jaw pain	<input type="checkbox"/> Y	<input type="checkbox"/> N	Tonsillitis	<input type="checkbox"/> Y	<input type="checkbox"/> N
Bone Density Medication	<input type="checkbox"/> Y	<input type="checkbox"/> N	Kidney disease	<input type="checkbox"/> Y	<input type="checkbox"/> N	Tuberculosis	<input type="checkbox"/> Y	<input type="checkbox"/> N
Cancer	<input type="checkbox"/> Y	<input type="checkbox"/> N	Liver disease	<input type="checkbox"/> Y	<input type="checkbox"/> N	Tumor or growth on head or neck	<input type="checkbox"/> Y	<input type="checkbox"/> N
Chemotherapy	<input type="checkbox"/> Y	<input type="checkbox"/> N	Low blood pressure	<input type="checkbox"/> Y	<input type="checkbox"/> N	Ulcer	<input type="checkbox"/> Y	<input type="checkbox"/> N
Cigarette, pipe, or cigar smoking	<input type="checkbox"/> Y	<input type="checkbox"/> N	Mitral valve prolapse	<input type="checkbox"/> Y	<input type="checkbox"/> N	Venereal disease	<input type="checkbox"/> Y	<input type="checkbox"/> N
Circulatory problems	<input type="checkbox"/> Y	<input type="checkbox"/> N	Nervous problems	<input type="checkbox"/> Y	<input type="checkbox"/> N	Weight loss, unexplained	<input type="checkbox"/> Y	<input type="checkbox"/> N
Congenital heart lesions	<input type="checkbox"/> Y	<input type="checkbox"/> N	Pacemaker	<input type="checkbox"/> Y	<input type="checkbox"/> N	Major surgery? _____	<input type="checkbox"/> Y	<input type="checkbox"/> N
Cortisone treatments	<input type="checkbox"/> Y	<input type="checkbox"/> N	Psychiatric care	<input type="checkbox"/> Y	<input type="checkbox"/> N	Hospitalized for? _____	<input type="checkbox"/> Y	<input type="checkbox"/> N
Diabetes	<input type="checkbox"/> Y	<input type="checkbox"/> N	Radiation treatment	<input type="checkbox"/> Y	<input type="checkbox"/> N	Do you wear contact lenses?	<input type="checkbox"/> Y	<input type="checkbox"/> N
Emphysema	<input type="checkbox"/> Y	<input type="checkbox"/> N	Respiratory disease	<input type="checkbox"/> Y	<input type="checkbox"/> N	Take any non-prescribed drugs?	<input type="checkbox"/> Y	<input type="checkbox"/> N
Epilepsy	<input type="checkbox"/> Y	<input type="checkbox"/> N	Scarlet fever	<input type="checkbox"/> Y	<input type="checkbox"/> N	If yes, what and how often? _____		

► Do you have any other dental or medical condition(s) that could affect your dental treatment? If so, please describe below:

WOMEN ONLY Pregnant? Due date _____ Y N Taking birth control pills? Y N Are you nursing? Y N

► Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). _____ Yes _____ No

► List all medications you are currently taking and the correlating diagnosis:

Med: _____ Dose: _____ Frequency: _____ For: _____

Med: _____ Dose: _____ Frequency: _____ For: _____

Med: _____ Dose: _____ Frequency: _____ For: _____

Med: _____ Dose: _____ Frequency: _____ For: _____

► Indicate all of your allergies below:

Aspirin Iodine Penicillin

Barbiturates Latex Sulfa

Codeine Local Other

anesthetic _____

Pharmacy name: _____ Phone (_____) _____

ACKNOWLEDGEMENT

► Check ONE and acknowledge with your signature below:

- I have had no change in my dental or medical history since my last visit.
- I attest that the dental and medical information above is current, complete, true, and accurate. I accept full responsibility for any information not updated or shared with the doctor.

Patient (or Guardian) Signature: _____ Date: ____/____/____

Name (if signing for minor): _____