

Patient Name
Patient Account No.

MEDICAL HISTORY

Medical Alert

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 the past two years? Yes No
3. Are you taking any medication, drugs or pills now? Yes No
 If yes, please list the 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-Phenopermine)	Yes	No		
Pondimen (Fenfluramine)	Yes	No		
Redux (Desfenfluramine)	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
 If yes, please list: _____
6. Have you been a patient in the hospital during the past five years? Yes No
7. Indicate which of the following you have had, or have at present. Circle "Yes" or "No" for each:

Heart (surgery, disease, attack): Yes No	Ulcers: Yes No	Hepatitis A or B: 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/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
Cortisone Medicine: Yes No	Latex Sensitivity: Yes No	Yellow Jaundice: Yes No
Swollen Ankles: Yes No	Allergies or Hives: Yes No	Neurological Disorder: Yes No
Stroke: Yes No	Sinus Trouble: Yes No	Epilepsy/Seizures: Yes No
Diet (special/restricted): Yes No	Radiation Therapy: Yes No	Fainting/Dizzy Spells: Yes No
Artificial Joints (hip/knee): Yes No	Chemotherapy: Yes No	Nervous/Anxious: Yes No
Kidney Trouble: Yes No	Tumors: Yes No	Psychiatric Care: Yes No
8. Do you use more than two pillows to sleep? 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** 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, you may release such information to you.

I will notify the dentist of any change in my health or medication.

I have been given the opportunity to read and review the Federal (HIPAA - Health Insurance Portability and Accountability Act). Other than is stated by the act or where Federal State or Local law requires, my health information will not be disclosed without further written authorization. I may revoke this authorization in writing at any time. Initial _____

Patient/Guardian Signature: _____ Date: _____

History Review
Dentist Signature: _____ Date: _____