

PATIENT'S NAME _____
Last First Initial

_____ Date of Birth

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER QUESTION.

COMMENTS

1. Physician's Name _____
Address _____
2. Are you under a physician's care ? _____ YES NO
Since when _____ Why? _____
3. When was your last complete physical exam? _____
4. Are you taking any medication or substances? _____ YES NO
(If yes, please list the medications on the back of the form) _____
5. Do you routinely take health related substances? _____ YES NO
6. Are you allergic to any medications or substances? _____ YES NO
7. Do you have any other allergies? _____ YES NO
8. Do you have any problems with penicillin, antibiotics, anesthetics or other medications? _____ YES NO
9. Are you sensitive to any metal or latex? _____ YES NO
10. Are you pregnant or suspect you may be? _____ YES NO
11. Do you use any birth control medications? _____ YES NO
12. Have you ever been treated or been told you might have heart disease? _____ YES NO
13. Do you have a pacemaker or an artificial heart valve implant? _____ YES NO
14. Have you ever had rheumatic fever? _____ YES NO
15. Are you aware of any heart murmurs? _____ YES NO
16. Do you have high or low blood pressure? _____ YES NO
17. Have you ever had a serious illness or major surgery ? YES NO If so explain _____
18. Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition? _____ YES NO
19. Do you have inflammatory diseases, such as arthritis or rheumatism? _____
20. Do you have any artificial joints/prosthetics? _____ YES NO
21. Do you have any blood disorders, such as anemia, leukemia etc _____ YES NO
22. Have you ever bled excessively after being cut or injured? _____ YES NO
23. Do you have any stomach problems? _____ YES NO
24. Do you have any kidney problems _____ YES NO
25. Do you have any liver problems? _____ YES NO
26. Are you diabetic? _____ YES NO
27. Do you have asthma? _____ YES NO
28. Do you have epilepsy or seizure disorders? _____ YES NO
29. Do you have had venereal disease? _____ YES NO
30. Have you been tested HIV positive? _____ YES NO
31. Do you have AIDS? _____ YES NO
32. Have you had or do you test positive for hepatitis? _____ YES NO
33. Do you or have you had T.B.? _____ YES NO
34. Do you smoke, chew, use snuff or any other forms of tobacco? _____ YES NO
35. Do you consume alcoholic beverages? _____ YES NO
36. Do you habitually use controlled substances? _____ YES NO
37. Have you had psychiatric treatment? _____ YES NO
38. Do you have any disease, condition, or problem not listed? _____ YES NO
If so, explain _____
39. Is there anything else we should know about your health that we have not covered in this form? _____
40. Have you ever taken the diet drug known as fen-phen _____ YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S / GUARDIAN SIGNATURE _____ DATE _____
DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MEDICAL HISTORY

MED ALERT