MEDICAL HISTORY

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 medications or drugs during the past two years? ☐ Yes ☐ No
3. Are you taking any medication, drugs or pills now? ☐ Yes ☐ No
   If yes, please list 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: ☐ Yes ☐ No Fen-Phen (Fenfluramine-Phenpermine)
   ☐ Yes ☐ No Pondimen (Fenfluramine)
   ☐ Yes ☐ No Redux (Dexfenfluramine)
   If yes to any of the above, did you have a medical exam for heart disease?_____
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?_____
7. Indicate which of the following you have had, or have at present. Check "Yes" or "No" to each item.

Heart (surgery, disease, attack)	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Chest Pain	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Congenital Heart Disease	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Heart Murmur	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Contact Lenses	☐ Yes ☐ No
Mitral Valve Prolapse	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Chronic Cough	☐ Yes ☐ No
Heart Pacemaker	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Rheumatic Fever	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
Arthritis/Rheumatism	☐ Yes ☐ No	Hay Fever	☐ Yes ☐ No
Cortisone Medicine	☐ Yes ☐ No	Latex sensitivity	☐ Yes ☐ No
Swollen Ankles	☐ Yes ☐ No	Allergies or Hives	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Diet (Special/Restriction)	☐ Yes ☐ No	Radiation Therapy	☐ Yes ☐ No
Artificial Joints (Hip,Knee)	☐ Yes ☐ No	Chemotherapy	☐ Yes ☐ No
Kidney Trouble	☐ Yes ☐ No	Tumors	☐ Yes ☐ No
Hepatitis A/B	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
A.I.D.S.	☐ Yes ☐ No	H.I.V. Positive	☐ Yes ☐ No
Cold Sores/Fever Blisters	☐ Yes ☐ No	Blood Transfusion	☐ Yes ☐ No
Hemophilia	☐ Yes ☐ No	Sickle Cell Disease	☐ Yes ☐ No
Bruise Easily	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No
Yellow Jaundice	☐ Yes ☐ No	Neurological Disorders	☐ Yes ☐ No
Epilepsy or Seizures	☐ Yes ☐ No	Fainting or Dizzy Spells	☐ Yes ☐ No
Nervous/Anxious	☐ Yes ☐ No	Psychiatric/Psychological	☐ 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 had any disease, condition, or problem not listed? ☐ Yes ☐ No
    If yes, please list:_____
11. **Pregnant?** ☐ Yes: Months?_____ ☐ No
12. **Nursing?** ☐ Yes ☐ No
13. **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, who may release such information to you. I will notify the doctor of change in my health or medication.

Patient/Guardian Signature_____ **Date**_____