

PATIENT NUMBER

welcome

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 THE QUESTION

COMMENTS

- 1. Physician's Name \_\_\_\_\_ Address \_\_\_\_\_ Tel: ( ) \_\_\_\_\_
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 medications in comments section or on the back of this form.)
5. Do you routinely take health related substances? (Vitamins, herbal supplements, natural products) . YES NO
6. Are you allergic to any medications or substances? (please list) . . . . . YES NO
7. Do you have any other allergies or hives? . . . . . YES NO
8. Do you have any problems with penicillin, antibiotics, anesthetics
or other medications? . . . . . YES NO
9. Are you sensitive to any metals 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 for or been told you might have heart disease? . . . . . YES NO
13. Do you have a pacemaker, an artificial heart valve implant, or
been diagnosed with mitral valve prolapse? . . . . . 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? (please circle) . . . . . 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. Have you ever taken Fosamax, Zometa, Aredia or any other oral or intravenous treatment
(bisphosphonates) for bone tumors, excessive calcium in your blood, or osteoporosis? . YES NO
20. Do you have inflammatory diseases, such as arthritis or rheumatism? . . . . . YES NO
21. Do you have any artificial joints/prosthesis? . . . . . YES NO
22. Do you have any blood disorders, such as anemia, leukemia, etc? . . . . . YES NO
23. Have you ever bled excessively after being cut or injured? . . . . . YES NO
24. Do you have any stomach problems? . . . . . YES NO
25. Do you have any kidney problems? . . . . . YES NO
26. Do you have any liver problems? . . . . . YES NO
27. Are you diabetic? . . . . . YES NO
28. Do you have fainting or dizzy spells? . . . . . YES NO
29. Do you have asthma? . . . . . YES NO
30. Do you have epilepsy or seizure disorders? . . . . . YES NO
31. Do you or have you had venereal or any sexually transmitted disease? . . . . . YES NO
32. Have you tested HIV positive? . . . . . YES NO
33. Do you have AIDS? . . . . . YES NO
34. Have you had or do you test positive for hepatitis? . . . . . YES NO
35. Do you or have you had T.B.? . . . . . YES NO
36. Do you smoke, chew, use snuff or any other forms of tobacco? . . . . . YES NO
37. Do you regularly consume more than one or two alcoholic beverages a day? . . . . . YES NO
38. Do you habitually use controlled substances? . . . . . YES NO
39. Have you had psychiatric treatment? . . . . . YES NO
40. Have you taken any prescription drugs fenfluramine, fenfluramine combined with
phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products? . . . . . YES NO
41. Do you have any disease condition, or problem not listed? If so, explain \_\_\_\_\_
42. Is there anything else we should know about your health that we have not covered in this form?
43. Would you like to speak to the Doctor privately about any problem? . . . . . YES NO

Large empty box for patient comments.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

DENTIST'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

ANEST. [ ]

MED. ALERT [ ]

MEDICAL HISTORY