

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