PATIENT NAME				MEDICAL HISTORY							
PREFERRED NAME				MEDICAL ALER	Т						
1.	hysician's Name ave you had any medical care within the past two years?									Yes	No
_	escribe————————————————————————————————————									.,	
	•	nedication or drugs during the past two years?								Yes Yes	No
3.		you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin?									No
	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? (circle if yes)  Fen-Phen  Pondimen  Redux  Other									V	NI.
_	If yes to any of the above, did you have a medical exam for heart issues?									Yes	No
	ave you ever taken bone loss prevention drugs such as Fosamax, Actonel,Boniva or other similar drugs?									Yes Yes	No No
0.	re you aware of having an allergic (or adverse) reaction to any substanceor medication? f yes, please specify									165	INO
_										.,	
	Have you been a patient in the hospital during the past five years?									Yes	No
8.	Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.										
	Heart (Surgery, Disease, Attack)	Yes	No	Ulcers		Yes	No	Hepatitis ABC (circ	:le)	Yes	No
	Chest Pain	Yes	No	Diabetes		Yes	No	Venereal Disease		Yes	No
	Congenital Heart Disease	Yes	No	Thyroid Problem	าร	Yes	No	A.I.D.S./H.I.V. Positive		Yes	No
	Heart Murmur	Yes	No	Glaucoma		Yes	No	Cold Sores/Fever Blisters		Yes	No
	High/Low Blood Pressure	Yes	No	Contact lenses.		Yes	No	Blood Transfusion		Yes	No
	Mitral Valve Prolapse	Yes	No	Emphysema		Yes	No	Hemophilia		Yes	No
	Artificial Heart Valve/Pacemaker	Yes	No	Chronic Cough.		Yes	No	Sickle Cell Disease		Yes	No
	Rheumatic Fever	Yes	No	Tuberculosis		Yes	No	Bruise Easily		Yes	No
	Arthritis/Rheumatism	Yes	No	Asthma		Yes	No	Liver Disease/Yellow Jaund	lice	Yes	No
	Cortisone Medicine	Yes	No	Hay Fever/Allerg	gy/Hives	Yes	No	Neurological Disorders		Yes	No
	Swollen Ankles	Yes	No	atex Sensitivity		Yes	No	Epilepsy or Seizures		Yes	No
	Stroke	Yes	No	Sinus Trouble		Yes	No	Fainting or Dizzy Spells		Yes	No
	Diet (Special/Restricted)		No	Radiation Thera		Yes	No	Nervous/Anxious			No
	Artificial Joints (hip, knee, etc.)		No	Chemotherapy		Yes	No	Psychiatric/Psychological C	are	Yes	No
	Kidney Trouble		No	Tumors			No				
9.	Have you lost or gained more tha	n 10 pc	ounds ir	the past year?						Yes	No
10.	Do you have or have you had any	y diseas	se, cond	dition, or problem n	ot listed?					Yes	No
	If yes, please list:										
11.	Women: Are you pregnant or t	think yo	u coulc	I be pregnant?	Yes	Months	No	Nursing? Yes	No		
12.	Do you use birth control prescrip	tions?.								Yes	No
8	understand the above informations and inswered all questions to the lask the respective health call any change in my health or latent/Guardian Signature	ie bes re pro medic	t of m vider ation.	y knowledge. S or agency, who	hould furth may releas	er inform se such i	nation	be needed, you have m	y per the d	missi loctor	on to r of
	-										
Н	istory Review										

\_Date\_

Dentist Signature \_