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(800) 243-4675

welcome

PATIENT NUMBER

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

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 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

COMMENTS

"NEW"
Updated Version
Question #19

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MED. ALERT

Form No. T140MH

MEDICAL HISTORY

Copy Courtesy of The Dental Record
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