Patient Name	**MEDICAL HISTORY**
Patient Account No.	Medical Alert

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 medication or drugs the past two years? Yes No
3. Are you taking any medication, drugs or pills now? Yes No
   If yes, please list the 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: Fen-Phen (Fenfluramine-Phenopermine) Yes No
   Pondimen (Fenfluramine) Yes No
   Redux (Desfenfluramine) Yes No
   If yes to any of the above, did you have a medical exam for heart issues? Yes No
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? Yes No
7. Indicate which of the following you have had, or have at present. Circle "Yes" or "No" for each:

Heart (surgery, disease, attack):	Yes	No	*Ulcers:*	Yes	No	*Hepatitis A or B:*	Yes	No
Chest Pain:	Yes	No	*Diabetes:*	Yes	No	*Venereal Disease:*	Yes	No
Congenital Heart Disease:	Yes	No	*Thyroid Problems:*	Yes	No	*A.I.D.S.:*	Yes	No
Heart Murmur:	Yes	No	*Glaucoma:*	Yes	No	*H.I.V. Positive:*	Yes	No
High Blood Pressure:	Yes	No	*Contact Lenses:*	Yes	No	*Cold Sores/Blisters:*	Yes	No
Mitral Valve Prolapse:	Yes	No	*Emphysema:*	Yes	No	*Blood Transfusion:*	Yes	No
Artificial Heart Valve:	Yes	No	*Chronic Cough:*	Yes	No	*Hemophilia:*	Yes	No
Heart Pacemaker:	Yes	No	*Tuberculosis:*	Yes	No	*Sickle Cell Disease:*	Yes	No
Rheumatic Fever:	Yes	No	*Asthma:*	Yes	No	*Bruise Easily:*	Yes	No
Arthritis/Rheumatism:	Yes	No	*Hay Fever:*	Yes	No	*Liver Disease:*	Yes	No
Cortisone Medicine:	Yes	No	*Latex Sensitivity:*	Yes	No	*Yellow Jaundice:*	Yes	No
Swollen Ankles:	Yes	No	*Allergies or Hives:*	Yes	No	*Neurological Disorder:*	Yes	No
Stroke:	Yes	No	*Sinus Trouble:*	Yes	No	*Epilepsy/Seizures:*	Yes	No
Diet (special/restricted):	Yes	No	*Radiation Therapy:*	Yes	No	*Fainting/Dizzy Spells:*	Yes	No
Artificial Joints (hip/knee):	Yes	No	*Chemotherapy:*	Yes	No	*Nervous/Anxious*	Yes	No
Kidney Trouble:	Yes	No	*Tumors:*	Yes	No	*Psychiatric Care:*	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 you had any disease, condition, or problem not listed? Yes No
    If yes, please list: _____
11. **Women**, are you? **Pregnant** Yes____months No **Nursing**? Yes No **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, you may release such information to you.

I will notify the dentist of any change in my health or medication.

I have been given the opportunity to read and review the Federal (HIPAA - Health Insurance Portability and Accountability Act). Other than is stated by the act or where Federal State or Local law requires, my health information will not be disclosed without further written authorization. I may revoke this authorization in writing at any time.

Initial _____

Patient/Guardian Signature: _____ Date: _____

History Review

Dentist Signature: _____ Date: _____