MEDICAL / DENTAL HISTORY

Patient Name ____
LAST **(Mr., Mrs., Miss)** FIRST INITIAL DATE OF BIRTH

Physician's Name and Phone Number ______________________________

LAST PHYSICAL EXAM ______________________________

LIST ALL MEDICATIONS YOU ARE NOW TAKING ______________________________

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HAVE YOU EVER TAKEN FEN-PHEN OR REDUX ?______________

ANY ALLERGIES ? ______________________________

HAVE YOU HAD ANY RECENT SURGERY OR MAJOR ILLNESS? ______________________________

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CIRCLE THE APPROPRIATE ANSWER

HAVE YOU EVER HAD OR HAVE AT PRESENT:

Condition		
High or low blood pressure	YES	NO
Heart attack	YES	NO
Heart murmer	YES	NO
Congenital heart lesions	YES	NO
Rheumatic fever	YES	NO
Artificial heart valve	YES	NO
Mitral valve prolapse / Leaky valve	YES	NO
Pacemaker	YES	NO
Chest pains / angina	YES	NO
Artificial joint / bone pins / plate	YES	NO
Radiation or chemotherapy	YES	NO
Cancer or tumor	YES	NO
Lung disease / asthma / emphysema	YES	NO
Shortness of breath	YES	NO
Tuberculosis	YES	NO
Glaucoma	YES	NO
Kidney disease	YES	NO
Diabetes	YES	NO
Blood transfusions	YES	NO
Hepatitis	YES	NO
AIDS or HIV	YES	NO
Stroke	YES	NO
Epilepsy or seizures	YES	NO
Athritis or rheumatism	YES	NO
Thyroid trouble	YES	NO
Fainting or dizzy spells	YES	NO
Bleeding disorders	YES	NO
Treatment for periodontal disease	YES	NO
Bleeding gums, unpleasant odor in mouth	YES	NO
Clenching or grinding of teeth	YES	NO
Orthodontic treatment	YES	NO
A fear of dental treatment	YES	NO

Date of last dental cleaning______________

Do you have any disease, condition or problem not listed?

If so, please explain ______________________________

PATIENT SIGNATURE ______________________________ DATE ______________

DENTIST SIGNATURE ______________________________ DATE ______________