

welcome

Patient number grid

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

COMMENTS

- 1. Physician's Name Address Tel:
2. Are you under a physician's care?
3. When was your last complete physical exam?
4. Are you taking any medication or substances?
5. Do you routinely take health related substances?
6. Are you allergic to any medications or substances?
7. Do you have any other allergies or hives?
8. Do you have any problems with penicillin, antibiotics, anesthetics or other medications?
9. Are you sensitive to any metals or latex?
10. Are you pregnant or suspect you may be?
11. Do you use any birth control medications?
12. Have you ever been treated for or been told you might have heart disease?
13. Do you have a pacemaker or an artificial heart valve implant?
14. Have you ever had rheumatic fever?
15. Are you aware of any heart murmurs?
16. Do you have high or low blood pressure?
17. Have you ever had a serious illness or major surgery?
18. Have you ever had radiation treatment, chemo treatment for tumor growth or other condition?
19. Do you have inflammatory diseases, such as arthritis or rheumatism?
20. Do you have any artificial joints/prosthesis?
21. Do you have any blood disorders, such as anemia, leukemia, etc?
22. Have you ever bled excessively after being cut or injured?
23. Do you have any stomach problems?
24. Do you have any kidney problems?
25. Do you have any liver problems?
26. Are you diabetic?
27. Do you have fainting or dizzy spells?
28. Do you have asthma?
29. Do you have epilepsy or seizure disorders?
30. Do you or have you had venereal disease?
31. Have you tested HIV positive?
32. Do you have AIDS?
33. Have you had or do you test positive for hepatitis?
34. Do you or have you had T.B.?
35. Do you smoke, chew, use snuff or any other forms of tobacco?
36. Do you regularly consume more than one or two alcoholic beverages a day?
37. Do you habitually use controlled substances?
38. Have you had psychiatric treatment?
39. Have you taken any prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products?
40. Do you have any disease condition, or problem not listed? If so, explain

Large empty box for patient comments

- 41. Is there anything else we should know about your health that we have not covered in this form?
42. Would you like to speak to the Doctor privately about any problem?

43. Have you ever had gum surgery? yes no

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE DATE

DENTIST'S SIGNATURE DATE

ANEST. box

MED. ALERT box

MEDICAL HISTORY