MEDICAL HISTORY

PATIENT NAME_____

1. Physician's Name_____ Phone Number_____
   What condition are you being treated for?_____
2. Have you been hospitalized in the last five years?_____If yes, for what condition?_____
3. **MEDICATIONS** Please list all medications and dosages that you are currently taking_____
   _____
4. Have you ever taken the following medications for weight loss: Fen-Phen(fenfluramine-phentermine), Pondimen (fenfluramine) or Redux (dexfenfluramine)?_____ If yes, have you had a medical exam of your heart?_____
5. Have you ever taken Fosamax or similar?_____ If yes, when and how long did you take it?_____
6. **ALLERGIES** Please list any medications or substances that you have had an adverse reaction to (if none, please answer NONE)_____
   _____
7. **WOMEN** Are you pregnant or think you might be?_____ Nursing?_____ Taking Oral Contraceptives?_____
8. Please indicate by circling which of the following you have had, or have at present:

Heart (Surgery, Disease, Attack)	Ulcers	Hepatitis A, B, or C
Congenital Heart Disease	Diabetes	Venereal Disease
Heart Murmur	Thyroid Problems	AIDS
Mitral Valve Prolapse	Emphysema	HIV Positive
Artificial Heart Valve	Tuberculosis	Cancer
Rheumatic Fever	Asthma	Blood Transfusion
High Blood Pressure	Latex Sensitivity	Hemophilia
Cortisone Medicine	Allergies or Hives	Sickle Cell Disease
Stroke	Sinus Trouble	Liver Disease
Artificial Joints (hip, knee, etc.)	Radiation Therapy	Epilepsy or Seizures
Kidney Trouble	Chemotherapy	Fainting or Dizzy Spells
Neurological Disorders	Psychological/Psychiatric Care	Nervous/Anxious

Comments regarding any above conditions_____
_____

9. Do you have or have you had any disease, condition, or problem not listed?_____ If yes, please describe_____
   _____

History Review

DENTAL HISTORY

What is reason for your visit today?_____
Previous Dentist Name/Address/Phone_____
Last dental examination?_____ Last dental cleaning?_____ Last full mouth Xrays?_____
How often do you brush?_____ How often do you floss?_____ Other dental aids used?_____
Are you having any problems now?_____ If yes, please describe_____
Please indicate by circling which of the following you have had, or have at present:

Sensitivity to hot or cold	Bleeding gums	Cold sores/ulcers	Clenching/grinding
Sensitvity to biting/chewing	Painful gums	Bad tastes/odors	Tired jaw muscles
Sensitivity to sweets	Loose teeth	Food packs between teeth	Clicking/popping of jaw
Orthodontic treatment	Periodontal treatment	Oral Surgery	Difficulty in opening or closing
Difficulty in chewing	Headaches/neckaches	Pain with ear/jaw joint	Smoking/tobacco use

Comments regarding any above conditions_____
_____
Have you ever had an upsetting experience with dental treatment?_____ Please explain_____
Is there anything else about having dental treatment that you would like us to know?_____

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, who may release such information to you. I will notify the dentist of any changes in my health status or medications.

Patient/Guardian Signature_____ Date_____
Dentist Signature_____ Date_____