

# WELCOME

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_  
Last First MI Date of Birth

Circle the appropriate answer. If you don't know the correct answer, write 'Don't Know'.

1. Physician's Name \_\_\_\_\_

Address \_\_\_\_\_ Tele: (\_\_\_\_) \_\_\_\_\_

Are you currently under a physician's care? Yes No

Since when? \_\_\_\_\_ Why? \_\_\_\_\_

			Notes
2. When was your last complete physical exam? _____			
3. Are you taking any medications or substances? _____ (List to the side)	Yes	No	
4. Are you taking <b>Aredia, Fosamax, or Zometa</b> ?	Yes	No	
5. Have you taken any prescription drugs fenfluramine, fenfluramine combined with phentermine(fen-phen), dexfenfluramine(redux), or other weight loss products?	Yes	No	
6. Do you routinely take other health substances? (vitamins, herbal supplements, etc)	Yes	No	
7. Have you ever had a serious illness or major surgery? _____ (Explain to the side)	Yes	No	
8. Have you ever had radiation or chemo treatment for a tumor or other condition?	Yes	No	
9. Are you allergic to any medications or substances? _____ (List to the side)	Yes	No	
10. Do you have any problems with penicillin, antibiotics, or other medications?	Yes	No	
11. Are you sensitive to any metals or latex?	Yes	No	
12. Are you pregnant or suspect you might be?	Yes	No	
13. Do you use any birth control medications?	Yes	No	
14. Have you ever been treated for or been told you have heart disease?	Yes	No	
15. <b>Do you have a pacemaker or an artificial heart valve implant?</b>	Yes	No	
16. Have you ever had rheumatic fever?	Yes	No	
17. Are you aware of any heart murmurs?	Yes	No	
18. Do you have high or low blood pressure?	Yes	No	
19. Do you have inflammatory diseases, such as arthritis or rheumatism?	Yes	No	
20. Do you have any artificial joints/prosthesis?	Yes	No	
21. Do you have any blood disorders, such as anemia, leukemia, etc?	Yes	No	
22. Have you ever bled excessively after being cut or injured?	Yes	No	
23. Do you have any stomach problems?	Yes	No	
24. Do you have any kidney problems?	Yes	No	
25. Do you have any liver problems?	Yes	No	
26. Are you diabetic?	Yes	No	
27. Do you have any fainting or dizzy spells?	Yes	No	
28. Do you have asthma?	Yes	No	
29. Do you have epilepsy or seizure disorders?	Yes	No	
30. Have you tested HIV positive?	Yes	No	
31. Do you have AIDS?	Yes	No	
32. Have you had or do you test positive to hepatitis?	Yes	No	
33. Do you or have you had T.B.?	Yes	No	
34. Do you smoke, chew, use snuff, or any other forms of tobacco?	Yes	No	
35. Do you regularly consume more than one or two alcoholic beverages a day?	Yes	No	
36. Do you habitually use controlled substances?	Yes	No	
37. Have you had psychiatric treatment?	Yes	No	
38. Do you have any disease condition, or problem not listed? _____ (Explain to the side)			
39. Is there anything else we should know about your health that we have not covered in this form?			

**I certify that the above information is complete and accurate to the best of my knowledge.**

Patient's/ Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

Dentist's Signature \_\_\_\_\_ Date \_\_\_\_\_

# MEDICAL HISTORY