MEDICAL HEALTH HISTORY

The information provided is important to your dental health.

Do you have or have you had any of the following?
(**Please check any that apply**)

- ❑ **NONE**
- ❑ Abnormal bleeding with extractions, surgery, or trauma
- ❑ AIDS or HIV positive
- ❑ Anemia or blood disorders
- ❑ Arthritis
- ❑ Artificial heart valve
- ❑ Artificial joint
- ❑ Asthma
- ❑ Back problems
- ❑ Blood disease
- ❑ Cancer or tumor
- ❑ Chemical dependency
- ❑ Chemotherapy or Radiation treatment
- ❑ Congenital heart lesions
- ❑ Cortisone treatments
- ❑ Cough, persistent or bloody
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Hepatitis ____ or other liver disease
- ❑ Herpes or cold sores
- ❑ High or low blood pressure
- ❑ Jaw pain
- ❑ Kidney or Liver disease
- ❑ Nervous problems
- ❑ Pacemaker
- ❑ Psychiatric Care
- ❑ Respiratory disease
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Scarlet fever
- ❑ Shortness of breath
- ❑ Sinus trouble
- ❑ Stroke
- ❑ Swollen neck glands
- ❑ Thyroid problems
- ❑ Tonsillitis
- ❑ Tuberculosis or other lung problems
- ❑ Tumor or growth on head or neck
- ❑ Ulcer
- ❑ Venereal disease
- ❑ Weight loss, unexplained
- ❑ Other (**Please list**)

_____
_____
_____

Are you **allergic** to, or have you reacted adversely to any of the following?
(**Please check any that apply**)

- ❑ **NO** known drugs allergies
- ❑ Aspirin
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Codeine or other narcotics
- ❑ Iodine
- ❑ Latex materials
- ❑ Local anesthetics ("Novocain")
- ❑ Penicillin or other antibiotics
- ❑ Sulfa drugs
- ❑ Other:_____

_____

Are you taking any of the following **medications**?
(**Please check any that apply**)

- ❑ I am **NOT** currently taking any medications
- ❑ Antibiotics or sulfa drugs
- ❑ Anticoagulants (blood thinners)
- ❑ Antidepressants or tranquilizers
- ❑ Aspirin
- ❑ Cortisone or other steroids
- ❑ High blood pressure medicine
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Osteoporosis (bone density) medicine
- ❑ Other (**Please list**)

_____
_____
_____

Name of your physician: _____

❑ **Surgeries** in the past 10 years? (**Please list**)

_____
_____
_____
_____

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

_____
_____

Please add anything else you would like us to know about you.

_____
_____
_____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ❑ **YES** or ❑ **NO**

Signature of patient (or guardian) _____ Date _____