1) Have you been under the care of a medical doctor during the past 2 years? Yes / No

If yes, for what? ____

Physician's name ____

Address ____Phone#____________________

2) Have you taken any medication or drugs during the past 2 years? Yes / No

3) Please list any medication, drugs, or pills you may be taking now:

____

4) Have you taken any prescriptions for weight loss (diet pills)? Yes / No
If yes, did you take any of the following?

Fen Phen	Yes / No
Pondimen	Yes / No
Redux	Yes / No

If yes to any of the above, did you have a medical examination for heart issues? Yes / No

5) Are you aware of having an allergic or adverse reaction to any medications or substances? Yes / No
If yes, please list:

____

6) Have you been a patient in hospital during the past 5 years? Yes / No
If yes, please list:

____

7) Indicate which of the following you have had or have at present:

	Yes	No		Yes	No		Yes	No
Heart (surgery, disease, attack)	☐	☐	Ulcers	☐	☐	Hepatitis A (infectious) B (serum)	☐	☐
Chest Pain	☐	☐	Diabetes	☐	☐	Veneral Disease	☐	☐
Congenital Heart Disease	☐	☐	Thyroid Problems	☐	☐	AIDS	☐	☐
Heart Murmur	☐	☐	Glaucoma	☐	☐	HIV+	☐	☐
High Blood Pressure	☐	☐	Contact Lenses	☐	☐	Cold Sores/Fever Blisters	☐	☐
Mitrovalve Prolapse	☐	☐	Emphysema	☐	☐	Blood Transfusion	☐	☐
Artificial Heart Valve	☐	☐	Chronic Cough	☐	☐	Haemophilia	☐	☐
Heart Pacemaker	☐	☐	Tuberculosis	☐	☐	Sickle Cell Disease	☐	☐
Rheumatic Fever	☐	☐	Asthma	☐	☐	Bruise Easily	☐	☐
Arthritis/Rheumatism	☐	☐	Hay Fever	☐	☐	Liver Disease	☐	☐
Cortisone Medicine	☐	☐	Latex Sensitivity	☐	☐	Yellow Jaundice	☐	☐
Swollen Ankles	☐	☐	Allergies or Hives	☐	☐	Neurological Disorders	☐	☐
Stroke	☐	☐	Sinus Trouble	☐	☐	Epilepsy or Seizures	☐	☐
Diet (special/restricted)	☐	☐	Radiation Therapy	☐	☐	Fainting or Dizzy Spells	☐	☐
Artificial Joints (hip, knee, etc)	☐	☐	Chemotherapy	☐	☐	Nervous / Anxious	☐	☐
Kidney Trouble	☐	☐	Tumors	☐	☐	Psychiatric / Psycological Care	☐	☐

8) Do you use more than 2 pillows to sleep? Yes / No

9) Have you lost or gained more than 4.5 kgs (10 lbs) in the past year? Yes / No

10) Do you have or have you had any disease, condition, or problem not listed? Yes / No
If yes, please list:

____

11) For Women:
Are you pregnant Yes / No Nursing Yes / No
If yes how many months ____________________ Are you taking birth control pills Yes / No

I understand that 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 doctor/dentist of any change in my health or medication.

Patient / Guardian Signature: Date:

History review

Dentist Signature Date