MEDICAL HISTORY - CONFIDENTIAL

NAME____ DATE___________________________ DOB________________________

1. Describe your present health: _______Excellent _______Good _______Fair _______Poor
2. List your current physicians: a.____ Type____________________
   b.____ Type____________________
3. Date of your last physical exam: _________/_______/_________ Purpose:______________________________________
4. **Have you ever seen a cardiologist ? No Yes**____
5. **Have you ever had heart testing or echocardiogram done? No Yes**___________________________________
6. Are you aware of any changes in your general health in the last 2 years? No Yes__________________________
7. Have you been hospitalized for illness or surgery in the past 2 years? No Yes__________________________
8. Have you been under a medical doctor's care during the past 2 years? No Yes__________________________
9. **Do you bleed excessively after a cut or tooth extraction? No Yes**__________________________
10. Is there a history of diabetes in your family? No Yes__________________________
11. **Have you ever been told that you needed to have an antibiotic before dental treatment? No Yes**__________
12. Indicate which of the following you have had, or have at the present time. **Circle "Yes" or No" to each item:**

Condition		
Heart Attack	**Yes**	**No**
Heart or Valve Surgery	**Yes**	**No**
Heart Murmur	**Yes**	**No**
Heart Trouble or Illness	**Yes**	**No**
Mitral Valve Prolapse	**Yes**	**No**
Damaged Heart Valve	**Yes**	**No**
Artificial Heart Valve	**Yes**	**No**
Congenital Heart Disease	**Yes**	**No**
Chest Pain	**Yes**	**No**
Heart Pacemaker	**Yes**	**No**
Rheumatic Fever	**Yes**	**No**
Rheumatic Heart Disease	**Yes**	**No**
Joint Replacement (hip, knee)	**Yes**	**No**
Metal implants (pins, rods, plates)	Yes	No
Blood Transfusion	Yes	No
Stroke	Yes	No
High Blood Pressure	Yes	No
Alcohol Dependency	Yes	No
Kidney Trouble	Yes	No
Liver Disease	Yes	No
Jaundice	Yes	No
Hepatitis A B or C	Yes	No
HIV + or AIDS	Yes	No
Hearing Loss	Yes	No
Nervous/Anxious	Yes	No
Glaucoma	Yes	No
Contact Lenses	Yes	No
Emphysema	Yes	No
Chronic Cough	Yes	No
Tuberculosis	Yes	No
Asthma	Yes	No
Hay Fever	Yes	No
Sinus Trouble	Yes	No
Cortisone Medicine	Yes	No
Bleeding Disorder (ie, hemophilia)	Yes	No
Cancer	**Yes**	**No**
Radiation Therapy	Yes	No
Chemotherapy	Yes	No
Tumors	Yes	No
Ulcers	Yes	No
Can you take NSHIDs? (Ie, Ibuprofen/Advil, Not Tylenol0	Yes	No
Epilepsy or Seizures	Yes	No
Fainting or Dizzy Spells	Yes	No
Thyroid Problems	Yes	No
Immunosuppressive disorders. (Ie, Epstein Barr, kidney dialysis, mononucleosis)	Yes	No
Autoimmune disorders(ie, lupus)	Yes	No
Venereal disease or STD	Yes	No
Cold Sores/Fever Blisters	Yes	No
Any transplanted organs	Yes	No
Psychiatric/Psychological Care	Yes	No
Osteoporosis (bone loss)	Yes	No
Other Infectious Disease	Yes	No
Recreational Drug Use	Yes	No

13. **Have you taken bisphosphonates- IV or oral)?** ie: Boniva, Fosamax **Yes No**
14. **.Do you have Diabetes? If yes, Type I or Type II_______ BGL_______ Last Meal_____ Last HHIC______Last_______**
15. ***Women*: Are you pregnant? Yes, Due Date:________ No Nursing: Yes No**
    Are you using Birth Control? Yes , Type:____________________________ No
16. **Have you ever taken medications for weight loss (diet pills)? Yes No**
    If yes, did you take: Fen-Phen (Fenfluramine-Phentermine); **Pondimen** (Fenfluramine); **Redux** (Dexfenfluramine)
    ____
17. Have you had any other illnesses, diseases, operations, conditions not listed above? Yes No
    If yes, please list____
18. Have you ever been turned down as a blood donor? Yes No
19. **Are you allergic or had an adverse reaction to any drugs or medications? Yes No**
    List:____
20. **Are you allergic or sensitive to latex? Yes No**
21. Please list all medications that you are currently taking (prescription and over-the-counter). Please include vitamin & herbal supplements:

Name of Drug	**Dosage and Frequency**	**Reason for Taking**

22. Do you use tobacco? No Yes, Cigarettes____ Cigars_____ Chewing Tobacco_____ Snuff_____ How Much?_____
23. Have you ever served in the military? Yes No Where_________________ When____________________
24. Person to contact in case of emergency________________________Relationship_______________Ph#_______________
25. Name of closest relative not living with you________________________Relationship_______________Ph#_______________

To the best of my knowledge, all the preceding answers are true and correct. If I have any changes in my health or medicines, I will inform the doctor at or before my next appointment.

Patient/Guardian Signature____ Date______________________

Continued

NAME______________________________ DATE______________________________