

Medical Information

1. Are you having pain or discomfort at this time?..... YES NO
2. Have you been a patient in the hospital during the last two years?..... YES NO
3. Are you now taking any medication or drugs?..... YES NO
If yes, please list: _____
4. Have you taken any medication or drugs during the last two years including appetite suppressants - fen-phen (fenfluramine & phentermine) or dexfenfluramine or fenfluramine?..... YES NO
5. Have you been under the care of a medical doctor during the last two years or since taking any of the appetite suppressants named above? YES NO
Physician's Name _____ Ph. # (____) _____
Address _____
6. Are you sensitive or allergic to any medication or anesthetics?..... YES NO
If yes, please list: _____
7. Indicate which of the following you have had or have at the present. Circle "yes or no" to each item.

Heart Failure..... YES NO	Artificial Joints (hip, knee, etc.)..... YES NO	Hepatitis A (infectious)..... YES NO
Heart Disease or Attack YES NO	Kidney Trouble..... YES NO	Hepatitis B (serum)..... YES NO
Angina Pectoris..... YES NO	Ulcers..... YES NO	Venereal Disease..... YES NO
Congenital Heart Disease YES NO	Diabetes..... YES NO	A.I.D.S..... YES NO
Heart Murmur..... YES NO	Thyroid Problems..... YES NO	H.I.V. Positive..... YES NO
High Blood Pressure..... YES NO	Glaucoma..... YES NO	Cold Sores/Fever Blisters..... YES NO
Arteriosclerosis..... YES NO	Cancer..... YES NO	Blood Transfusion..... YES NO
Mitral Valve Prolapse..... YES NO	Emphysema..... YES NO	Hemophilia..... YES NO
Artificial Heart Valve..... YES NO	Chronic Cough..... YES NO	Anemia..... YES NO
Heart Pacemaker..... YES NO	Tuberculosis..... YES NO	Sickle Cell Disease..... YES NO
Heart Surgery..... YES NO	Asthma..... YES NO	Bruise Easily..... YES NO
Rheumatic Fever..... YES NO	Hay Fever..... YES NO	Liver Disease..... YES NO
Arthritis..... YES NO	Allergies or Hives..... YES NO	Yellow Jaundice..... YES NO
Rheumatism..... YES NO	Sinus Trouble..... YES NO	Epilepsy or Seizures..... YES NO
Cortisone Medicine..... YES NO	Radiation Therapy..... YES NO	Fainting or Dizzy Spells..... YES NO
Drug Addiction..... YES NO	Chemotherapy..... YES NO	Nervousness..... YES NO
Stroke..... YES NO	Developmentally Disabled..... YES NO	Tumors..... YES NO
Allergy to Latex..... YES NO	Allergy to Metal (jewelry, etc.)..... YES NO	
8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired?..... YES NO
9. Do your ankles swell during the day?..... YES NO
10. Do you use more than two pillows to sleep?..... YES NO
11. Have you lost or gained more than ten pounds in the past year?..... YES NO
12. Do you ever wake up from sleep and feel short of breath?..... YES NO
13. Are you on a special diet?..... YES NO
14. Do you have or have you had any disease, condition, or problem not listed?..... YES NO
If yes, please list: _____

FOR WOMEN ONLY:

Are you pregnant? Yes ___ What month? _____ No ___ Are you nursing? Yes ___ No ___ Are you taking birth control pills? Yes ___ No ___

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature _____ Date _____