MEDICAL HISTORY - CONFIDENTIAL

NAME_____ DATE_____

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:**

Heart Attack	**Yes**	**No**	Kidney Trouble	Yes	No	Radiation Therapy	Yes	No
Heart or Valve Surgery	**Yes**	**No**	Liver Disease	Yes	No	Chemotherapy	Yes	No
Heart Murmur	**Yes**	**No**	Jaundice	Yes	No	Tumors	Yes	No
Heart Trouble or Illness	**Yes**	**No**	Hepatitis A B or C	Yes	No	Ulcers	Yes	No
Mitral Valve Prolapse	**Yes**	**No**	HIV + or AIDS	Yes	No	Diabetes	Yes	No
Damaged Heart Valve	**Yes**	**No**	Hearing Loss	Yes	No	Epilepsy or Seizures	Yes	No
Artificial Heart Valve	**Yes**	**No**	Nervous/Anxious	Yes	No	Fainting or Dizzy Spells	Yes	No
Congenital Heart Disease	**Yes**	**No**	Glaucoma	Yes	No	Thyroid Problems	Yes	No
Chest Pain	**Yes**	**No**	Contact Lenses	Yes	No	Immunosuppressive disorders	Yes	No
Heart Pacemaker	**Yes**	**No**	Emphysema	Yes	No	(Ie, Epstein Barr, kidney dialysis, mononucleosis)		
Rheumatic Fever	**Yes**	**No**	Chronic Cough	Yes	No	Autoimmune disorders (ie, lupus)	Yes	No
Rheumatic Heart Disease	**Yes**	**No**	Tuberculosis	Yes	No	Venereal disease or STD	Yes	No
Joint Replacement (hip, knee)	**Yes**	**No**	Asthma	Yes	No	Cold Sores/Fever Blisters	Yes	No
Metal implants (pins, rods, plates)	Yes	No	Hay Fever	Yes	No	Any transplanted organs	Yes	No
Blood Transfusion	Yes	No	Sinus Trouble	Yes	No	Psychiatric/Psychological Care	Yes	No
Stroke	Yes	No	Cortisone Medicine	Yes	No	**Osteoporosis** (bone loss)	Yes	No
High Blood Pressure	Yes	No	Bleeding Disorder (ie, hemophilia)	Yes	No	Other Infectious Disease	Yes	No
			Cancer	**Yes**	**No**	Recreational Drug Use	Yes	No

13. ***Women*: Are you pregnant? Yes, Due Date:_____ No Nursing: Yes No**
    Are you using Birth Control? Yes , Type:_____ No
14. **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)
    _____
15. Have you had any other illnesses, diseases, operations, conditions not listed above? Yes No
    If yes, please list_____
16. Have you ever been turned down as a blood donor? Yes No
17. **Are you allergic or had an adverse reaction to any drugs or medications? Yes No**
    List:_____
18. **Are you allergic or sensitive to latex? Yes No**
19. 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

20. Do you use tobacco? No Yes, Cigarettes____ Cigars_____ Chewing Tobacco_____ Snuff_____ How Much?_____
21. Have you ever served in the military? Yes No Where_____ When_____
22. Person to contact in case of emergency_____Relationship_____Ph#_____
23. 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_____

MEDICAL HISTORY - CONFIDENTIAL

Continued

NAME_____ DATE_____