

Patient's Name _____ / _____ / _____
Last First MI Date of Birth

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE ANSWER PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

1. Physician's Name: _____
Address: _____
2. Are you under a physician's care?.....YES / NO
Since when? _____ For What? _____
3. When was your last complete physical exam? _____
4. Are you taking any medication or substances? (please list on reverse side) YES / NO
5. Do you routinely take health related substances? (vitamin, herbal supplements, natural products)?.....YES / NO
6. Are you allergic to any medications or substances? (please list on reverse side)..... YES / NO
7. Do you have any other allergies or hives?.....YES / NO
8. Do you have any problems with penicillin, antibiotics, anesthetics or other medications?.....YES / NO
9. Are you sensitive to any metals or latex?.....YES / NO
10. Are you pregnant or suspect you may be?.....YES / NO
11. Do you use any birth control medications?..... YES / NO
12. Have you ever been treated for or been told you might have heart disease?.....YES / NO
13. Do you have a pacemaker, an artificial heart valve, implant or been diagnosed with mitral valve prolapse? YES / NO
14. Have you ever had rheumatic fever resulting in rheumatic heart disease?..... YES / NO
15. Are you aware of any heart murmurs? YES / NO
16. Do you have blood pressure problems? YES / NO
17. Have you ever had a serious illness or major surgery? (Detail on reverse side or separate paper) .YES / NO
18. Have you ever had radiation treatment or chemotherapy for a tumor, growth or other condition?... YES / NO
19. Do you have inflammatory diseases, such as arthritis or rheumatism?.....YES / NO
20. Do you have any artificial joints or prostheses?..... YES / NO
21. Do you have any blood disorders such as anemia, leukemia, etc.?..... YES / NO
22. Have you ever bled excessively after being cut or injured?.....YES / NO
23. Do you have any stomach problems?.....YES / NO
24. Do you have any kidney problems?.....YES / NO
25. Do you have any liver problems?..... YES / NO
26. Are you diabetic?.....YES / NO
27. Do you have fainting or dizzy spells?..... YES / NO
28. Do you have asthma?.....YES / NO
29. Do you have epilepsy or seizure disorders?..... YES / NO
30. Do you or have you ever had a venereal disease?.....YES / NO
31. Have you tested positive for HIV?..... YES / NO
32. Do you have AIDS?.....YES / NO
33. Have you had or do you test positive for Hepatitis?.....YES / NO
34. Do you or have you had Tuberculosis (TB)?.....YES / NO
35. Do you smoke, chew, use snuff or any other forms of tobacco? How much? _____YES / NO
36. Do you regularly consume more than one or two alcoholic beverages a day?.....YES / NO
37. Have you had psychiatric treatment?.....YES / NO
38. Do you habitually use controlled substances, legal or illegal?.....YES / NO
39. Have you taken any of the following? Fenfluramine, fenfluramine combined with phentermine (fen-phen), Dexfenfluramine (redux), or other weight loss products?.....YES / NO
40. Do you have any disease condition, or problem not listed? If so, list _____
41. Is there anything else we should know about your health that we have not covered in this form? _____
42. Would you like to speak to the Doctor privately about any problem?.....YES / NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S/ GUARDIAN'S SIGNATURE **DATE**

DENTIST'S SIGNATURE **DATE**