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P	ATIE	TIME	NUN	ABE.	R

Last		

First

Initial

Date of Birth

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

1.	Physician's Name
	Physician's NameAddress
2	Are you under a physician's care?YES NO
	Since when ————Why —————
3	When was your last complete physical exam?
4	Are you taking any medication or substances?YES NO
т.	(If yes, please list medications in comments section or on the back of this form.)
5	Do you routinely take health related substances? (Vitamins, herbal supplements, natural products) YES NO
	Are you allergic to any medications or substances? (please list) YES NO
	Do you have any other allergies or hives?
	Do you have any problems with penicillin, antibiotics, anesthetics
0.	or other medications?YES NO
0	Are you sensitive to any metals or latex? YES NO
9.	Are you progrant or cusposet you may be?
10.	Are you pregnant or suspect you may be?
	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
4.4	been diagnosed with mitral valve prolapse?
14.	Have you ever had rheumatic fever?YES NO
	Are you aware of any heart murmurs?
16.	Do you have high or low blood pressure? (please circle)
17.	Have you ever had a serious illness or major surgery?YES NO
	If so, explain
18.	Have you ever had radiation treatment, chemo treatment for tumor,
1525	growth or other condition?
19.	. Have you ever taken Fosamax, Zometa, Aredia or any other oral or intravenous treatment
	(bisphosphonates) for bone tumors, excessive calcium in your blood, or osteoporosis? .YES NO
	Do you have inflammatory diseases, such as arthritis or rheumatism? YES NO
	Do you have any artificial joints/prosthesis? YES NO
	Do you have any blood disorders, such as anemia, leukemia, etc? YES NO
	. Have you ever bled excessively after being cut or injured? YES NO
	. Do you have any stomach problems? YES NO
25.	Do you have any kidney problems?YES NO
26.	. Do you have any liver problems?
	Are you diabetic?
28.	. Do you have fainting or dizzy spells?
29	. Do you have asthma?
30.	. Do you have epilepsy or seizure disorders?
31.	. Do you or have you had venereal or any sexually transmitted disease? YES NO
32	. Have you tested HIV positive?
33	. Do you have AIDS?
34	. Have you had or do you test positive for hepatitis? YES NO
35	. Do you or have you had T.B.?
36	. Do you smoke, chew, use snuff or any other forms of tobacco? YES NO
37	. Do you regularly consume more than one or two alcoholic beverages a day?YES NO
38	. Do you habitually use controlled substances? YES NO
39	. Have you had psychiatric treatment?
40	Have you taken any prescription drugs fenfluramine, fenfluramine combined with
	phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products? YES NO
41	. Do you have any disease condition, or problem not listed? If so, explain
	. Is there anything else we should know about your health that we have not covered in this form?
43	. Would you like to speak to the Doctor privately about any problem? YES NO
	ERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE
	TIENT'S / GUARDIAN'S SIGNATURE
IP	TILINI O / GOALDIAN O SIGNATURE

COMMENTS

ANEST.

DENTIST'S SIGNATURE.

MEDICAL HISTORY

MED. ALERT

Form No. T140MH



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P	ATH	ENT	NILIN	/IRE	R

Last

First

Date of Birth

CIRCLE THE APPROPRIATE ANSWER,	IF YOU DON'T KNOW	THE CORRECT	ANSWER PLEASE
WRITE "DON'T KNOW" ON THE LINE A			

1.	Physician's Name		
	Physician's NameAddressTel:(
2.	Are you under a physician's care?	YES	NO
	Since when ————————————————————————————————————		
3.	When was your last complete physical exam?		
4.	Are you taking any medication or substances?	YES	NO
	(If yes, please list medications in comments section or on the back of this form.)		
;	Do you routinely take health related substances? (Vitamins, herbal supplements, natural products)	YES	NO
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	Do you have any other allergies or hives?		
	Do you have any problems with penicillin, antibiotics, anesthetics	120	110
	or other medications?	YES	NO
	Are you sensitive to any metals or latex?		
	Are you pregnant or suspect you may be?		
1	Do you use any birth control medications?	VEC	NO
	Have you ever been treated for or been told you might have heart disease?		
	Do you have a pacemaker, an artificial heart valve implant, or	ILO	NO
J.	been diagnosed with mitral valve prolence?	VEC	NO
Λ	been diagnosed with mitral valve prolapse? Have you ever had rheumatic fever?	VEC	NO
4.	Are you aware of any heart murmurs?	VEC	NO
o.	Do you have high or law blood processing? (places sinels)	VEC	NO
0.	Do you have high or low blood pressure? (please circle)	YES	NO
1.	Have you ever had a serious illness or major surgery?		NO
0	If so, explain		
ŏ.	Have you ever had radiation treatment, chemo treatment for tumor,	VEO	NO
_	growth or other condition?		NO
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	Have you tested HIV positive?		
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4.	Have you had or do you test positive for hepatitis?	YES	NO
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			2
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	TIENT'S / GUARDIAN'S SIGNATURE		
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COMMENTS

____ DATE

ANEST.

DENTIST'S SIGNATURE_

DATE

MED. ALERT