

Patient Name

Soc. Sec. #

Birthdate

Last

First

Initial

Month

Day

Year

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

COMMENTS

- 01. Physician's name _____
Address: _____
- 02. Are you under a physician's care? YES NO
Since when? _____ Why? _____
- 03. When was your last **COMPLETE** physical exam? _____
- 04. Are you taking any medication or substances? _____
(If yes, please list meds in comments section at right or on backside.)
- 05. Do you routinely take health-related substances? _____
- 07. Do you have any other **ALLERGIES** _____
- 08. Do you have any **PROBLEMS** with **SULPHA, PENICILLIN, ANTIBIOTICS**
ANESTHETICS or other meds? YES NO
- 09. 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 **TOLD** you might have **HEART DISEASE**? .. YES NO
- 13. Do you have a **PACEMAKER** or an **ARTIFICIAL HEART VALVE** implant? YES NO
- 14. Have you ever had **RHEUMATIC FEVER**? YES NO
- 15. Are you aware of any **HEART MURMURS**? YES NO
- 16. Do you have **HIGH** or **LOW BLOOD PRESSURE**? YES NO
- 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,
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/PROSTHESIS**? 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 PROBELMS**? YES NO
- 26. Are you **DIABETIC**? YES NO
- 27. Do you have **ASTHMA**? YES NO
- 28. Do you have **EPILEPSY** or **SEIZURE DISORDERS**? YES NO
- 29. Do you have or have you had **VENEREAL DISEASE**? YES NO
- 30. Have you tested **HIV POSITIVE**? YES NO Do you have **AIDS**? YES NO
- 31. Have you had or do you test positive for **HEPATITIS**? YES NO
- 32. Do you or have you had **T.B.**? YES NO
- 33. Do you **SMOKE, CHEW, USE SNUFF** or any other **FORMS OF TOBACCO**? YES NO
- 34. Do you consume **ALCOHOLIC** beverages? YES NO
- 35. Do you habitually use **CONTROLLED** substances? YES NO
- 36. Have you had psychiatric treatment? YES NO
- 37. Have you taken **FENFLURAMINE** or **FENFLURAMINE** combined w/ **PHENTERMINE**
(fen-phen), dexfenfluramine (**redux**) or other weight loss products? YES NO
- 38. Do you often go on **DIETS** that **DON'T WORK**? YES NO
- 39. Do you have any disease, condition or problem not listed? YES NO
If yes, please explain: _____
- 40. Is there anything else we should know about your health that we have not covered
on this form? If yes, please explain: _____ YES NO
- 41. Would you like to speak with the Doctor privately about any problem? YES NO

Large empty box for patient comments.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____
DENTIST'S SIGNATURE _____ DATE _____

Medical Alert

MEDICAL HISTORY