

PATIENT'S NAME _____
Last First Initial Date of Birth

PARENT'S NAME _____
Last First Initial

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

Comments

1. Physician's Name _____
Address _____
Phone number _____
2. Is the patient under a physician's care?.....yes no
Since when _____ Why _____
3. When was the last date of a complete physical exam for the patient? _____
4. Is the patient taking any medication or substance?.....yes no
(If yes, please list) _____
5. Does the patient take any other health related substances? (vitamins, herbal supplements)

6. Is the patient allergic to any medication or substances?.....yes no
(if yes, please list) _____
7. Does the patient have any allergies or hives?.....yes no
8. Does the patient have allergies or reactions to penicillin, antibiotics, anesthetics, or other
medications?.....yes no
(if yes, please list _____
9. Does the patient have allergies or sensitivity to latex or metal?.....yes no
(if yes, please list) _____
10. Does the patient use any birth control medication?.....yes no
11. Is the patient pregnant or suspect they may be?.....yes no
12. Does the patient have a congenital heart disease for which they are seeing a
Cardiologist?.....yes no
13. Has the patient had surgery for any heart repair.....yes no
(pace maker, artificial heart valve implant, or been diagnosed with a mitral valve
prolapse)? _____
14. Does the patient have high blood pressure?.....yes no
15. Has the patient ever had a serious illness or major surgery?.....yes no
(If yes, please explain) _____
16. Has the patient ever had rheumatic fever?.....yes no
17. Has the patient ever had radiation treatments, chemo treatments for tumor growth or
other condition.....yes no
18. Has the patient every taken Fosamax, Zometa, Aredia or any other oral or intravenous
treatment (bisphosphonates) for bone tumors, excessive calcium in your blood, or
osteoporosis?.....yes no
19. Does the patient have inflammatory diseases? (arthritis or rheumatism).....yes no
20. Does the patient have any artificial joints/prosthesis?.....yes no
21. Does the patient have any blood disorders? (anemia, leukemia etc).....yes no
22. Has the patient ever bled excessively after being cut or injured?.....yes no
23. Does the patient have stomach problems?.....yes no
24. Does the patient have liver problems?.....yes no
25. Is the patient diabetic?.....yes no
26. Does the patient have fainting or dizzy spells?.....yes no

- 27. Does the patient have asthma?.....yes no
- 28. Does the patient have epilepsy or seizure disorders?.....yes no
- 29. Has the patient ever had venereal or any sexually transmitted disease?.....yes no
- 30. Has the patient tested positive for HIV?.....yes no
- 31. Does the patient have AIDS?.....yes no
- 32. Has the patient had or have they ever tested positive for hepatitis?.....yes no
- 33. Has the patient had or ever tested positive for TB?.....yes no
- 34. Does the patient smoke, chew use snuff or any other form of tobacco?.....yes no
- 35. Does the patient regularly consume more than one or two alcoholic beverages per day?.....yes no
- 36. Does the patient habitually use controlled substances?.....yes no
- 37. Has the patient had psychiatric treatment?.....yes no
- 38. Has the patient taken any prescription drugs fenfluramine, fenfluramine combined with phentermine, (fen-phen), dexfenfluramine (redux), or other weight loss products?.....yes no
- 39. Does the patient have any disease condition, or problem not listed? If so, please Explain _____

Comments

Is there anything else we should know about the patient's health that we have not covered in this form? _____

40. Would you like to speak to the Doctor privately about any problem?.....yes no

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE:

PARENT'S/GUARDIAN'S SIGNATURE _____ **DATE** _____

DENTIST'S SIGNATURE _____ **DATE** _____

MEDICAL HISTORY CHANGES

I certify there have been no changes in the patient's medical history since last visit

Date of last visit

Patient Name

PARENT/GUARDIAN SIGNATURE _____ **DATE** _____

MEDICAL HISTORY
