Welcome

Patient's Name _____
Last First Initial Date of Birth

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

1. Physicians Name _____
   Address_____
   _____
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 medications or substances? _____ YES NO
   (If yes, please list medications in comments section)
5. Do you routinely take health related substances? _____ YES NO
6. Are you allergic to any medications or substances?_____ YES NO
7. Do you have any other allergies? _____ 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 or 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 or leukemia, etc? _____ YES NO
22. Have you ever bled excessively after being cut or injured? ___ YES NO
23. Do you have stomach problems? _____ YES NO
24. Do you have kidney problems? _____ YES NO
25. Do you have liver problems? _____ 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. Have you tested HIV positive? _____ YES NO
30. Do you have AIDS? _____ YES NO
31. Have you had or do you test positive for hepatitis?_____ YES NO
32. Do you have or have you had T.B.? _____ YES NO

COMMENTS

33. Have you had psychiatric treatment? _____ YES NO
34. Do you smoke, chew, use snuff or any other forms of tobacco? _ YES NO
35. Do you consume alcoholic beverages? _____ YES NO
36. Do you habitually use controlled substances? _____ YES NO
37. Have you ever taken Fosomax, Zometa, Aredia, or any other oral or intraveneous treatment (bisphosphonates) for bone tumors, excessive calcium in your blood, or osteoporosis? _____ YES NO
38. Have you taken any prescription for drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products? _____
39. Do you have any disease condition, or problem not listed? If so, explain _ _____
40. Is there anything else we should know about your health that we have not covered on this form? _____
41. Would you like to speak to the Doctor privately about any problem? ____

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S/GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____