Medical History

English Rows Dental Group

Please answer each question or write "don't know" on the line **Please write any further comments on the back of this page**

Physician's Name/Address/Phone _____

_____

Are you under a physician's care ..... YES NO

Since When?_____ Why? _____

When was your last complete physical exam? _____

Are you taking any medications? ..... YES NO

(If yes, please list names and dosages on the back of this form)

Do you routinely take vitamins or other supplements? ..... YES NO

Do you have any allergic reactions to any medications or substances? ..... YES NO (e.g. latex, penicillin, metals, etc.)

If so, please explain : _____

_____

Do you have any other adverse reactions to antibiotics, anesthetics, or other medications or materials? (e.g. stomach irritation, rashes, hives, etc.)

If so, please explain: _____

Are you pregnant or suspect that you may be? ..... YES NO

Do you use any birth control medications? ..... YES NO

Have you ever been treated for or been told you might have heart disease? ..... YES NO

Do you have a pacemaker or an artificial heart valve implant? ..... YES NO

Have you ever had rheumatic fever? ..... YES NO

Are you aware of any heart murmurs? ..... YES NO

Do you have high or low blood pressure? ..... YES NO

Have you ever had a serious illness or major surgery? ..... YES NO

If so, please explain: _____

Have you ever had radiation treatment, chemo treatment, or I.V. Fosamax for tumor, growth or other condition? ..... 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

Do you have any kidney problems? ..... YES NO

Do you have any liver problems? ..... YES NO

Are you diabetic? ..... YES NO

Do you have fainting or dizzy spells? ..... YES NO

Do you have epilepsy or a seizure disorder? ..... YES NO

Do you have asthma? ..... YES NO

Do you or have you had venereal disease? ..... YES NO

Have you ever tested positive for HIV? ..... YES NO

Do you have AIDS? ..... YES NO

Have you had or do you test positive for hepatitis? ..... YES NO

Do you or have you had T.B.? ..... YES NO

Do you smoke, chew, use snuff or any other forms of tobacco? ..... YES NO

Do you consume alcoholic beverages? ..... YES NO

Do you habitually use controlled substances? ..... YES NO

Have you had psychiatric treatment? ..... YES NO

Have you taken the prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (reduc), or other weight loss products? ..... YES NO

Do you have any disease condition, or problem not listed? YES NO

If so, please explain: _____

_____

Is there anything else we should know about your health that we have not covered in this form?

_____

Would you like to speak to the Doctor privately about any problem? ..... YES NO

Do you have any other questions or concerns?

_____

_____

I CERTIFY THAT THE ABOVE IS COMPLETE AND ACCURATE

Sign: _____

PATIENT'S/GUARDIAN'S SIGNATURE DATE