

MEDICAL HISTORY

Name of Physician _____ Phone # _____

When was your last physical exam? _____

Have you been under the care of a physicians care in the past three years? _____ If so, for what reason _____

Have you visited any other countries in the past three years? _____ If so, were you seriously ill during your visit? _____

What was the illness? _____ Country _____

Have you been in a hospital or health care institution in the past three years? _____ If so, where? _____

Have you had a blood transfusion anytime in the past three years? _____

Have you worked in any health care facility anytime during the past three years? _____

If so, when? _____ What type of facility? _____ Did you care for patients? _____

Have you been in the Armed Forces in the past three years? _____ If so, where? _____

Do you presently live in a nursing home or retirement center? _____

Are you currently taking any recreational drugs such as cocaine? _____

Please list **all** current medications (including Birth Control) _____

Type:	Dosage:	How many times daily:	What For:
_____	_____ mg	_____	_____
_____	_____ mg	_____	_____
_____	_____ mg	_____	_____
_____	_____ mg	_____	_____
_____	_____ mg	_____	_____
_____	_____ mg	_____	_____

Are you allergic to any drugs or medications? _____ If so, which ones? _____

Are you allergic to Valium? Yes _____ No _____

Do you have or have you ever had any of the following?

- | | | | |
|----------------------------|-------------------------|---------------------------|-----------------------------|
| _____ Rheumatic Fever | _____ Tuberculosis | _____ High Blood Pressure | _____ Heart Trouble |
| _____ Radiation Treatments | _____ Hepatitis A,B,C | _____ Nervous Disorders | _____ Mitral Valve Prolapse |
| _____ Pacemaker | _____ Allergies | _____ Diabetes | _____ Asthma |
| _____ Stroke | _____ Epilepsy | _____ Heart Disease | _____ HIV or Aids |
| _____ Fainting | _____ Artificial Joints | _____ Dialysis | |

Any other serious illnesses? _____ Name them _____

Do you perspire excessively at night? _____

Do you have persistent diarrhea? _____

Have you lost weight recently without dieting? _____ Approx. # of pounds _____ Have you taken Pondimin/Fen-Phen? _____

Do you have persistent purplish rashes and/or bruises? _____

Do you frequently feel "run down" and have a low grade fever? _____

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I authorize the insurance company to issue payment directly to the dentist. I authorize the use of this signature for all insurance claims. I understand that I am responsible for all fees in their entirety.

SIGNATURE _____ DATE _____