Patient's Name: _____
Last First Initial DOB

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

1. Physician's Name _____
   Address _____
   _____ Phone: _____
2. Are you under a physician's care? . . . . . Yes No
   Since when? _____ Why? _____
3. When was your last physical exam? _____
4. Are you taking any medications? . . . . . Yes No
   (If yes, please list medications in comments section or on the back of this form.)
5. Do you routinely take health related substances? . . . . . Yes No
6. Are you allergic to any medications or substances? (please list) . . . . . Yes No
7. Do you have any other allergies? . . . . . Yes No
8. Do you have any problems with antibiotics, anesthetics or other medications? . . . . . Yes No
9. Are you pregnant or suspect you might be? . . . . . Yes No
10. Do you use any birth control medications? . . . . . Yes No
11. Are you sensitive to any metals or latex? . . . . . Yes No
12. Have you ever been treated for or been told you might have heart disease? . . . . . Yes No
13. Have you ever had rheumatic fever? . . . . . Yes No
14. Do you have a pacemaker or artificial heart valve implant? . . . . . Yes No
15. Are you aware of any heart murmurs? . . . . . Yes No
16. Do you have high or low blood pressure? (please circle) . . . . . Yes No
17. Have you ever had a major surgery or serious illness? . . . . . Yes No
    If so, explain. _____
18. Have you ever had chemo treatment for tumor, growth or other condition or radiation treatment? . . . . . Yes No
19. Do you have any inflammatory diseases such as arthritis or rheumatism? . . . . . Yes No
20. Do you have any artificial joints or prosthesis? . . . . . Yes No
21. Do you have any blood disorders such as anemia, leukemia? . . . . . Yes No
22. Are you diabetic? . . . . . Yes No
23. Do you have dizzy or fainting spells? . . . . . Yes No
24. Have you ever bled excessively? . . . . . Yes No
25. Do you have any disease or transplant operation that has depressed your immune system? . . Yes No
26. Do you have any stomach problems? . . . . . Yes No
27. Do you have kidney problems? . . . . . Yes No
28. Do you have any liver problems? . . . . . Yes No
29. Do you have asthma? . . . . . Yes No
30. Do you or have you ever had T.B.? . . . . . Yes No
31. Do you have epilepsy or seizure disorders? . . . . . Yes No
32. Do you or have you had a venereal disease? . . . . . Yes No
33. Have you had or do you test positive for hepatitis? . . . . . Yes No
34. Do you smoke or use any form of tobacco? . . . . . Yes No
35. Do you consume alcoholic beverages? . . . . . Yes No
36. Do you habitually use controlled substances? . . . . . Yes No
37. Have you had psychiatric treatment? . . . . . Yes No
38. Have you taken any prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products? . . . . . Yes No
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 in this form? _____
41. Would you like to speak to the Doctor privately about any problem . . . . . Yes No

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION GIVEN TO DISTINCTIVE DENTAL CONCEPTS IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

Rev. 6-2003

ANEST.

MED. ALERT

MEDICAL HISTORY