

Physician's Name _____ Ph# (____) _____

1. Are you having pain or discomfort at this time?..... **Yes No**
2. Have you been a patient in the hospital during the last two years? **Yes No**
If yes, please explain _____
3. Are you now taking any medications or drugs? **Yes No**
If yes, please list _____
4. Have you been under the care of a medical doctor during the last two years?..... **Yes No**
If yes, please explain _____
5. Have you ever taken Fen - PHEN (fenfluramine & phentermine), dexfenfluramine, fenfluramine or any medication or drugs during the last two years including appetite suppressants **Yes No**
6. Have you been under the care of a medical doctor since taking any of the appetite suppressants named above? **Yes No**
7. Are you sensitive or allergic to any medication or anesthetics? **Yes No**
If yes please list: _____

8. Please, indicate which of the following you have had or have now. **Circle "yes" or "no" to each item.**

Heart Failure	Y / N	Artificial Joints (hip, knee, etc)	Y / N	Hepatitis A (infectious)	Y / N
Heart Disease or Attack	Y / N	Kidney Trouble	Y / N	Hepatitis B (serum)	Y / N
Angina Pectoris	Y / N	Ulcers	Y / N	Venereal Disease	Y / N
Congenital Heart Disease	Y / N	Diabetes	Y / N	A.I.D.S.	Y / N
Heart Murmur	Y / N	Thyroid Problems	Y / N	HIV Positive	Y / N
High Blood Pressure	Y / N	Glaucoma	Y / N	Cold Sores/Fever Blisters	Y / N
Arteriosclerosis	Y / N	Cancer	Y / N	Blood Transfusion	Y / N
Mitral Valve Prolapse	Y / N	Emphysema	Y / N	Hemophilia	Y / N
Artificial Heart Valve	Y / N	Chronic Cough	Y / N	Anemia	Y / N
Heart Pacemaker	Y / N	Tuberculosis	Y / N	Sickle Cell Disease	Y / N
Heart Surgery	Y / N	Asthma	Y / N	Bruise Easily	Y / N
Rheumatic Fever	Y / N	Hay Fever	Y / N	Liver Disease	Y / N
Arthritis	Y / N	Allergies or Hives	Y / N	Yellow Jaundice	Y / N
Rheumatism	Y / N	Sinus Trouble	Y / N	Epilepsy or Seizures	Y / N
Allergy to Latex	Y / N	Radiation Therapy	Y / N	Fainting or Dizzy Spells	Y / N
Cortisone Medicine	Y / N	Chemotherapy	Y / N	Nervousness	Y / N
Drug Addiction	Y / N	Developmentally	Y / N	Tumors	Y / N
Stroke	Y / N	Allergy to Metals (jewelry, etc)	Y / N		Y / N

9. When you walk up stairs or take a walk do you have to stop because of pain in you chest, shortness of breath, or because you are very tired?..... **Yes No**
10. Do your gums occasionally bleed when brushing or flossing? **Yes No**
11. Are your teeth sensitive to hot or cold liquids or foods?..... **Yes No**
12. Have you lost or gained more than ten pounds in the past year?..... **Yes No**
13. Do you ever wake up from sleep and feel short of breath?..... **Yes No**
14. Are you on a special diet?..... **Yes No**
15. Do you have or have you had any disease, condition, or problem not listed?..... **Yes No**
If yes, please list: _____

For Women Only:

Are you pregnant? Yes ___ No ___ What month? ___ Are you nursing? Yes ___ No ___ Are you taking birth control pills? Yes ___ No ___

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature _____ **Date** _____
Parent or Responsible Party _____ **Relationship to** _____
Patient _____

FOR OFFICE USE ONLY: Reviewed by Dr. _____ Date _____