Welcome _____ Age _____ Date _____

Med Alert

Patient's Name Date of Birth / / **q** Female **q** Male

Last First M. Initial

COMMENTS

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

1. Physician's Name: _____
   Address: _____ Telephone No: _____
   Are you under a physicians care? _____ YES NO
2. When was your last complete physical exam? _____ YES NO
3. Are you taking any medication or substances? _____ YES NO
   (If yes, please list medications in comments section or on the back of this form)
4. Do you routinely take health related substances?: (vitamins, herbal supplements, natural products) ____ YES NO
5. Are you allergic to any medications or substances? (please list) : _____ YES NO
6. Do you have any other allergies or hives? _____ YES NO
7. Do you have any problems with penicillin, antibiotics, anesthetics or other medications? _____ YES NO
8. Are you sensitive to any Metals or Latex _____ YES NO
9. Are you pregnant or suspect you may be? _____ YES NO
10. D you use any birth control medications? _____ YES NO
11. Have you ever been treated for or been told you might have heart disease? _____ YES NO
12. Do you have a pacemaker, an artificial heart valve implant, or been diagnosed with mitral valve prolapse? _____ YES NO
13. Have you ever had rheumatic fever? _____ YES NO
14. Are you aware of any heart murmurs? _____ YES NO
15. Do you have high or low blood pressure? _____ YES NO
16. Have you ever had a serious illness or major surgery? _____ YES NO
17. Have you ever taken Fosamax, Zometa, Aredia or any other oral or intravenous treatment (bisphosphonates) for bone tumors, excessive calcium in your blood, or osteoporosis? _____ YES NO
19. Have you ever had a serious illness or major surgery? _____ YES NO
20. Do you have inflammatory diseases, such as arthritis or rheumatism? _____ YES NO
21. Do you have any artificial joints/prosthesis? _____ YES NO
22. Do you have any blood disorders, such as anemia, leukemia, etc.? _____ YES NO
23. Have you ever bled excessively after being cut or injured? _____ YES NO
24. Do you have any stomach problems? _____ YES NO
25. Do you have any kidney problems? _____ YES NO
26. Do you have any liver problems? _____ YES NO
27. Are you diabetic? _____ YES NO
28. Do you have fainting or dizzy spells _____ YES NO
29. Do you have asthma? _____ YES NO
30. Do you have epilepsy or seizure disorder? _____ YES NO
31. Do you or have you had venereal or any sexually transmitted disease? _____ YES NO
32. Have you tested HIV positive? _____ YES NO
33. Do you have AIDS? _____ YES NO
34. Have you had or do you test positive for hepatitis? _____ YES NO
35. Do you or have you had T.B. _____ YES NO
36. Do you smoke, chew, use snuff or any other forms or tobacco? _____ YES NO
37. Do you regularly consume more than one or two alcoholic beverages a day? _____ YES NO
38. Do you habitually use controlled substances? _____ YES NO
39. Have you had psychiatric treatment? _____ YES NO
40. Have you taken any prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products? _____ YES NO
41. Do you have any disease condition, or problem not listed? If so, explain _____ YES NO
42. Is there anything else we should know about your health that we have not covered in this form? _____ YES NO
43. Would you like to speak to the Doctor privately about any problem? _____ YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S GUARDIAN'S SIGNATURE: _____ DATE _____

DENTIST SIGNATURE: _____ DATE _____

MEDICAL HISTORY

Advanced Dental Care
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