

**Welcome to Our Office!**

In order to serve you promptly we will need the following information.  
All information will be strictly confidential.

NAME: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Who is your medical Doctor? \_\_\_\_\_ What is your occupation? \_\_\_\_\_

**MEDICAL HISTORY: Do you have or have you had any of the following?**

- |     |    |                               |     |    |                     |
|-----|----|-------------------------------|-----|----|---------------------|
| Yes | No | Heart Attack                  | Yes | No | Hepatitis A, B or C |
| Yes | No | Rheumatic Fever               | Yes | No | Low Blood Pressure  |
| Yes | No | Mitral Valve Prolapse         | Yes | No | Epilepsy/Convulsion |
| Yes | No | AIDS or HIV Positive          | Yes | No | High Blood Pressure |
| Yes | No | Clotting or Bleeding Problems | Yes | No | Kidney Disease      |
| Yes | No | Respiratory Problems          | Yes | No | Fainting            |
| Yes | No | Thyroid Problems              | Yes | No | Tuberculosis        |
| Yes | No | Heart Disease                 | Yes | No | Asthma              |
| Yes | No | Stroke                        | Yes | No | Sinusitis           |
| Yes | No | Cardiac Pacemaker             | Yes | No | Cancer              |
| Yes | No | Heart Murmur                  | Yes | No | Diabetes            |
| Yes | No | Joint Replacement             | Yes | No | Arthritis           |
| Yes | No | Liver Disease                 | Yes | No | Other _____         |
| Yes | No | Emphysema                     |     |    |                     |

**Yes No Do you need to be pre-medicated with antibiotics for dental visits?**

- Yes No Any other diseases or medical problems? \_\_\_\_\_
- Yes No Are you currently being treated by another dental specialist? \_\_\_\_\_
- Yes No Are you allergic to any antibiotics, pain medications or latex rubber? \_\_\_\_\_
- Yes No Are you allergic to any other medicines, drugs, food, or other? \_\_\_\_\_

- Yes No In the past, have you taken the weight loss medications "Redux", fenfluramine or dexfenfluramine?
- Yes No If yes, have you consulted with your physician or cardiologist?
- Yes No If yes, has he/she told you NOT to pre-medicate?

What medications are you currently taking? (Including pain medications, vitamins, etc.) \_\_\_\_\_

Women: Are you pregnant? Yes \_\_\_\_\_ No \_\_\_\_\_ Possibly \_\_\_\_\_ If yes, what trimester? \_\_\_\_\_

Do you take birth control pills? Yes \_\_\_\_\_ No \_\_\_\_\_

*The information given above is true to the best of my knowledge. I will inform the dentist of any change in my health and/or medication.*

\_\_\_\_\_  
*Name* \_\_\_\_\_  
*Date*