

WELCOME

The Center for Cosmetic and Family Dentistry

Patient's Name _____
Last First Initial Date of Birth

1. Physician's Name _____
Tel: () _____
2. Are you under a physician's care? YES NO
3. When was your last complete physical exam? _____
4. Are you taking any medication or substances? YES NO
Please list : _____
5. Are you allergic to any medications or substances? 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. Do you use any birth control medications? YES NO
11. Have you ever had a serious illness or major surgery? YES NO
12. Have you ever taken Fosamax, Zometa or Aredia for bone tumors,
excessive calcium in your blood, or osteoporosis? YES NO
13. Do you smoke, chew, use snuff or any other forms of tobacco? YES NO
14. Do you regularly consume more than 1 or 2 alcoholic beverages a day? YES NO
15. Do you habitually use controlled substances? YES NO
16. Have you had psychiatric treatment? YES NO
17. Have you taken any prescription drugs fenfluramine, fenfluramine combined
with phentermine, dexfenfluramine or other weight loss products? YES NO
18. Do you have any disease condition, or problem not listed? If yes, please explain

19. Would you like to speak to the Doctor privately about any problem? YES NO

20. **Please check mark if you have had or do have any of the following:**

- | | | |
|--|--|---|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> pacemaker | <input type="checkbox"/> artificial heart valve |
| <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> rheumatic fever | <input type="checkbox"/> heart murmurs |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> low blood pressure | <input type="checkbox"/> radiation treatment |
| <input type="checkbox"/> Chemo treatment | <input type="checkbox"/> tumor growth | <input type="checkbox"/> arthritis |
| <input type="checkbox"/> Rheumatism | <input type="checkbox"/> artificial joints | <input type="checkbox"/> artificial prosthesis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> leukemia | <input type="checkbox"/> bleed excessively |
| <input type="checkbox"/> Stomach problems | <input type="checkbox"/> kidney problems | <input type="checkbox"/> liver problems |
| <input type="checkbox"/> Diabetic | <input type="checkbox"/> fainting/dizzy spells | <input type="checkbox"/> asthma |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> seizures | <input type="checkbox"/> sexual transmitted disease |
| <input type="checkbox"/> AIDS/ HIV positive | <input type="checkbox"/> T.B. | <input type="checkbox"/> Hepatitis |

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S/GUARDIAN'S SIGNATURE _____ DATE _____
DENTIST'S SIGNATURE _____ DATE _____

Doctor/Staff Comments _____

MEDICAL HISTORY