

Patient Medical History

Today's Date _____ / _____ / _____
Name _____ Sex _____ Age _____ Height _____ Weight _____ BP _____
Referred By _____ Reason for Referral _____
Physician _____ Dentist _____

Circle any of the following which you have had or have at present:

Heart Trouble	Sinus Trouble	Other Blood Disorder
Heart Murmur	Fainting Spells	Epilepsy or Seizures
Heart Disease	Ulcers/Colitis	Stroke
Rheumatic Fever	Other Liver Disease	Nervousness
Chest Pain	Diabetes	Thyroid Problems
High Blood Pressure	High Blood Sugar	Back Pains
Ankle Swelling	Low Blood Sugar	Back Injury
Shortness of Breath	Excess Thirst	Neck Injury
Pneumonia	Excess Urination	Arthritis
Tuberculosis (TB)	Problem Urinating	Glaucoma
Other lung disease	Kidney Problems	Tumor or Cancer
Asthma	Anemia	AIDS or HIV+
Chronic Cough	Hemophilia	Blood Transfusion
Emphysema	Joint Replacement	Alcohol/Drug Use/Abuse

Other Medical Problems _____
List all previous hospitalizations _____
Allergies to Medications (Y | N) Please List _____
List all medications you are currently taking _____

Do you pre-medicate with antibiotics prior to dental appointments? (Y | N)
If "YES", list the antibiotic _____ amount taken _____

Please answer each of the following questions.

- Do you take Aspirin or Aspirin-Containing Products? _____ How much and how often? _____
- Do you smoke? _____ How much? _____ Do you wear contact lenses? _____
- Have you ever been treated with Cortisone, Prednisone, or other Steroids? _____ When? _____

Is there a family history of: Cancer _____ Diabetes _____ Problems with Anesthesia _____
Heart Disease _____ Vascular Disease _____ Stroke _____ Other _____
Previous Orthodontic Treatment? _____ Sleep Apnea? _____ Heavy Snoring? _____
Problems breathing through your nose? _____ Have you ever taken medication for weight loss? _____
If "YES", did you take any of the drugs listed below (indicate "YES" or "NO"):
_____ Fen-Phen (fenfluramine + phentermine) _____ Pondimin (fenfluramine) _____ Redux (dexfenfluramine)
If you have ever taken any of the above drugs, have you had a medical examination to ensure that your heart valves were not affected? (Y | N)

For Women: Are you pregnant or trying to conceive? _____ Nursing? _____ Are you taking birth control pills? _____
Would you like to take a pregnancy test? (Y | N)

NOTE: Antibiotics may neutralize the effect of birth control pills, allowing for conception and pregnancy. If you are placed on Antibiotics by Dr. Grove and are using birth control pills, you should consult with your personal physician to initiate additional forms of birth control and continue them until advised by him that you can return solely to the use of birth control pills.

Is there any other condition concerning your health that your doctor should be aware of? _____
If "YES", please explain _____

I have read and fully understand the above medical questionnaire. I acknowledge that all answers have been recorded truthfully. I will not hold Dr. Grove, nor any member of his staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature _____ Date _____

Medical Update: I have read my health history dated ____ / ____ / ____ and confirm that it adequately states past and present conditions, and that I have had the opportunity to discuss it with my doctor.

Exceptions or Changes _____

Signature _____ Date _____ Doctor's Initials _____