PATIENT'S NAME _____
Last First Initial Date of Birth

CIRCLE THE APPROPRIATE ANSWER

COMMENTS

1. Physicians Name _____
   Address _____
2. Have you ever had a serious Illness or operation? . . . . . YES NO
   If so, explain _____
3. Are you under a physician's care? . . . . . YES NO
   For what reason? _____
4. When was your last complete physical exam? _____
5. Are you taking any medication? . . . . . YES NO
   If so, please list the medications and dosages in the comment box.
   Do you routinely take health related substances? . . . . . YES NO
6. Do you have any allergies? . . . . . YES NO
   Are you allergic to any medications or substances? . . . . . YES NO
   Do you have any problems with penicillin, antibiotics, anesthetics or other medications? . . . . . YES NO
7. Do you have an allergy to Latex? . . . . . YES NO
8. Have you been treated for or been told you might have heart disease? . . . . . YES NO
   Do you have a pacemaker or an artificial heart valve implant? . . . . . YES NO
9. Are you aware of any heart murmurs? . . . . . YES NO
10. Have you ever had rheumatic fever? . . . . . YES NO
11. Have you ever had surgery, radiation treatment, chemo treatment for a tumor, growth or other condition? . . . . . YES NO
12. Do you have high or low blood pressure? . . . . . YES NO
13. Do you have inflammatory diseases, such as arthritis or rheumatism? . . . . . YES NO
14. Do you have any artificial joints/prosthesis? . . . . . YES NO
15. Do you have any blood disorders, such as anemia, leukemia, etc.? . . . . . YES NO
16. Have you ever bled excessively after being cut or injured? . . . . . YES NO
17. Do you have any stomach problems? . . . . . YES NO
18. Do you have any kidney problems? . . . . . YES NO
19. Do you have any liver problems? . . . . . YES NO
20. Are you diabetic? . . . . . YES NO
21. Do you have asthma? . . . . . YES NO
22. Do you have epilepsy or seizure disorders? . . . . . YES NO
23. Do you or have you had venereal disease? . . . . . YES NO
24. Are you HIV positive or you have AIDS? . . . . . YES NO
25. Have you ever had hepatitis? . . . . . YES NO
26. Do you or have you had T.B.? . . . . . YES NO
27. Do you smoke or use smokeless tobacco? . . . . . YES NO
28. Do you consume alcoholic beverages? . . . . . YES NO
29. Are you pregnant or suspect you may be? . . . . . YES NO
30. Have you ever taken a diet medication such as Fen-phen or Redux? . . . . . YES NO
    If so, has your physician checked you for possible heart damage? . . . . . YES NO
31. Do you have any disease, condition, or problem not listed? If so, explain _____
32. Have you, close friends, or family members traveled to Liberia, Sierra Leone, Guinea or anywhere in the Western Africa area? _____
33. Is there anything else we should know about your health that we have not covered in this form? _____
34. 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 SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

MEDICAL HISTORY