☐ Dr.
☐ Mr. ☐ Mrs.
☐ Miss ☐ Ms._____ Date_____

The thoroughness of this medical history is designed for your safety, and your complete answers will assist us in treating you with consideration for your special needs.

Please check the appropriate box (☐ YES or ☐ NO).

1. Do you have a current medical problem? ..... ☐ YES ☐ NO
2. Are you currently under the care of a physician? ..... ☐ YES ☐ NO
3. Have you been hospitalized or had a serious illness within the past five years? ..... ☐ YES ☐ NO
4. Do you have heart trouble or any form of cardiovascular disease? ..... ☐ YES ☐ NO

   Angina ☐ YES ☐ NO Stroke ☐ YES ☐ NO

   Heart attack ☐ YES ☐ NO Heart surgery ☐ YES ☐ NO
5. Have you ever taken fenfluramine HCI (commonly known as fen-fen) or redox? ..... ☐ YES ☐ NO
6. Do you have diabetes? ..... ☐ YES ☐ NO

   If YES, how is it controlled?_____
7. Do you have hypoglycemia? ..... ☐ YES ☐ NO

   If YES, how is it controlled?_____
8. Do you have kidney disease? ..... ☐ YES ☐ NO
9. Have you ever had hepatitis? ..... ☐ YES ☐ NO

   If YES, type and date?_____
10. Have you ever had liver disease or jaundice? ..... ☐ YES ☐ NO
11. Do you have any blood disease? ..... ☐ YES ☐ NO

    Anemia ☐ YES ☐ NO AIDS or positive test ☐ YES ☐ NO

    Leukemia ☐ YES ☐ NO Venereal disease ☐ YES ☐ NO

121. Do you have any problems with excessive bleeding? ..... ☐ YES ☐ NO
13. Do you have stomach or intestinal ulcers? ..... ☐ YES ☐ NO
14. Have you ever had tuberculous? Date? ..... ☐ YES ☐ NO
15. Do you have emphysema, asthma or breathing problems? ..... ☐ YES ☐ NO
16. Do you have any form of arthritis? ..... ☐ YES ☐ NO

    If YES, what type?_____
17. Have you ever had a hip or other joint replacement? ..... ☐ YES ☐ NO
18. Have you ever had any injury, pain, or soreness from your jaw joint? ..... ☐ YES ☐ NO
18. Have you ever had any chronic head, neck or back problems? ..... ☐ YES ☐ NO
20. Have you ever suffered trauma to your head or neck, such as a car accident? ..... ☐ YES ☐ NO

    If YES, describe?_____
21. Do you have fainting spells, convulsions or epilepsy? ..... ☐ YES ☐ NO
22. Have you had surgery, radiation or other treatment for a tumor or growth? ..... ☐ YES ☐ NO
23. Do you have glaucoma? ..... ☐ YES ☐ NO

    ☐ Right eye ☐ Left eye ☐ Both eyes

HEALTH HISTORY

24. Is your diet medically prescribed? ..... ☐ YES ☐ NO

If YES, please explain_____

25. Are you pregnant? Expected delivery date?_____ ..... ☐ YES ☐ NO

265. Have you reached menopause? ..... ☐ YES ☐ NO

27. Are you allergic to or have you had any unusual reaction to any medications? If YES, please list. ..... ☐ YES ☐ NO

_____

28. Have you ever been advised not to take a particular medication? ..... ☐ YES ☐ NO

29. Have you ever been advised to take prophylactic antibiotics before dental treatment? ..... ☐ YES ☐ NO

30. Please list any medications you are taking? Include birth control and any non-prescription medications that you take on a regular basis. ..... ☐ YES ☐ NO

NAME	PURPOSE	FREQUENCY	SINCE

31. Alcohol (_____) drinks per day.

32. Tobacco (_____) packs per day for approximately (_____) years.

33. Recreational drugs such as cocaine, marijuana, stimulants or depressants may have a fatal interaction with local anesthetics or other common medications. Please describe the use of any drugs or discuss in complete confidentiality with the doctor.

_____

_____

To the best of my knowledge, all the preceding answers are true and correct. If I have any change in my health or medications, I will inform the doctor at my next appointment. If deemed advisable, I grant permission for my physician to be contacted for details and advice. I further authorize the taking of radiographs, photographs, or other diagnostic measures appropriate for a thorough evaluation. Authorization is also given for dental treatment to be rendered by Dr.Watson or office staff.

Signature: _____ Date:_____

NAME	REVIEWER	CHANGES SINCE LAST REVIEW

After five years or if major changes in history, please complete new form

HEALTH HISTORY