Dr. Beverly Morris, D.D.S. *MEDICAL HISTORY*

Patients Name _____

Last First Initial Date of Birth

.CIRCLE THE APPROPRIATE ANSWER, IF YOU DON'T KNOW THE CORRECT ANSWER PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

1. Physician's Name _____
   City Located In _____Phone ( ) _____
2. When was your last complete physical exam? _____
3. Are you taking any medication, vitamins, or other substances? …….. YES NO
   (If yes, please list medications in comments section)
4. Are you allergic to any medications or substances? (please list) …….. YES NO
5. Do you have any problems with penicillin, antibiotics, anesthetics, other meds? … YES NO
6. Are you sensitive to metals or latex? …… YES NO
7. Are you pregnant or suspect you may be? …….. YES NO
8. Are you taking any birth control medications? …… YES NO
9. Have you ever been treated for or been told you might have heart disease? ……. YES NO
10. Do you have a pacemaker, artificial heart valve implant, or been diagnosed with mitral valve prolapse? ……. YES NO
11. Have you ever had rheumatic fever or heart murmur? …… YES NO
12. Do you have high or low blood pressure? (please circle which) ……. YES NO
13. Have you ever had a serious illness or major surgery? …… YES NO
    If so, explain _____
14. Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition? ……. YES NO
15. Have you ever taken Fosamax, Zometa, Aredia or any other oral or intravenous treatment (biophosphonates) for bone tumors, excessive calcium in your blood, or osteoporosis? …… YES NO
16. Do you have inflammatory diseases, such as arthritis or rheumatism? …… YES NO
17. Do you have any artificial joints/ prosthesis? …….. YES NO
18. Do you have any blood disorders, such as anemia, leukemia, etc? ……. YES NO
19. Have you ever bled excessively after being cut or injured? …… YES NO
20. Do you have any stomach problems? …….. YES NO
21. Do you have any kidney problems? ……. YES NO
22. Do you have any liver problems? ……. YES NO
23. Are you diabetic? ……. YES NO
24. Do you have fainting or dizzy spells? …….. YES NO
25. Do you have asthma? …… YES NO
26. Do you have epilepsy or seizure disorder? …… YES NO
27. Do you or have you had venereal or any sexual transmitted disease? …….. YES NO
28. Have you tested HIV positive or do you have AIDS? …….. YES NO
29. Have you had or do you test positive for hepatitis? …… YES NO
30. Do you or have you had TB? …… YES NO
31. Do you smoke, chew, use snuff or any other forms of tobacco? …….. YES NO
32. Do you regularly consume more than one or two alcoholic beverages a day? …….. YES NO
33. Do you habitually use controlled substances? …… YES NO
34. Have you had psychiatric treatment? …… YES NO
35. Have you taken any prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products? … YES NO
36. Is there anything else we should know about your health that we have not covered on this form? YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

DENTIST SIGNATURE _____ DATE _____

Medical Alert