MEDICAL HISTORY

Note: This information is confidential and essential to provide the best possible care for you.

Physician's Name (Medical Doctor) _____City_____
Physician's phone number_____
1. Have you been treated by a doctor or been in the hospital in the last 2 years? Yes___ No____ If yes, Why?_____
_____
_____.
2. List Medications you are currently taking:_____
_____.

3. Have you ever taken any of the drugs collectively referred as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phenterminr), Pondimin (fenfluarimine) and Redux (dexfenfluramine.) Yes___No___

4. Have you ever had a blood transfusion? Yes___ No ____ If yes, give approximate dates _____
(Women) Are you pregnant? Yes ____ No ___ Nursing? Yes____ No ____ Taking birth control pills? Yes___ No ____

5. Are you currently taking or have you previously taken bisphosphonate medications, such as Actonel within the past twelve years? Yes_____ No_____

Pre-Medication

6. Has a Doctor or Specialist ever told you that you need to be premedicated with antibiotics prior to dental treatment due to health conditions such as: (Heart Murmur/Artificial Joints/Mitral Valve Prolapse)? Yes____ No____

7. Have you had, or do you presently have, any of the following conditions? Please check yes or no.

Heart Attack/Disease/Surgery	Yes___No___	Diabetes	Yes___No___
Angina or Chest Pain	Yes___No___	Radiation Treatment	Yes___No___
Heart Murmur	Yes___No___	AIDS or HIV Positive	Yes___No___
Rheumatic Fever	Yes___No___	Hepatitis or Liver Disease	Yes___No___
Congenital Heart Lesions	Yes___No___	Hemophilia or Excessive Bleeding	Yes___No___
Artificial Heart Valves	Yes___No___	Asthma	Yes___No___
Heart Pacemaker	Yes___No___	Stomach or Intestinal Ulcers	Yes___No___
Artificial Joint	Yes___No___	Thyroid Disease	Yes___No___
Stroke	Yes___No___	Drug or Alcohol Problem	Yes___No___
Kidney Disease	Yes___No___	Epilepsy	Yes___No___
Cancer or Tumors	Yes___No___	Lung Disease	Yes___No___
High Blood Pressure	Yes___No___	Tuberculosis	Yes___No___
Low Blood Pressure	Yes___No___	Sinus Trouble	Yes___No___

Allergies: Have you ever had an allergic reaction or unusual reaction to any of the following medications?

Aspirin	Yes___No___	Erythromycin or other Antibiotics	Yes___No___
Barbiturates or Tranquilizers	Yes___No___	Latex	Yes___No___
Codeine or other Narcotics	Yes___No___	Penicillin	Yes___No___
Dental Local Anesthetics	Yes___No___	Tylenol	Yes___No___
		Other_____	

The above information is accurate and complete to the best of my knowledge. If changes in my health or medicine occur, I will inform Dr. Bradford prior to treatment. I will not hold my dentist or any member of his/her staff responsible.

Dated:_____ Signature_____
(Patient or Guardian, if patient is a minor)