MEDICAL HISTORY REVIEW

1 Patient Information

Date_____ Cell Phone #_____ Patient ID #(for office use) _____

Patient Name_____
First Name Middle Initial Last Name

2 Health History

Physician's Name_____ Date of last visit_____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ioimin, Adipex, Fastin (phentermine) , Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Y ☐ N

Place a mark on "yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Y ☐ N	Epilepsy	☐ Y ☐ N	Respiratory Disease	☐ Y ☐ N
Anemia	☐ Y ☐ N	Fainting or dizziness	☐ Y ☐ N	Rheumatic Fever	☐ Y ☐ N
Arthritis, Rheumatism	☐ Y ☐ N	Glaucoma	☐ Y ☐ N	Scarlet Fever	☐ Y ☐ N
Artificial Heart Valves	☐ Y ☐ N	Headaches	☐ Y ☐ N	Shortness of Breath	☐ Y ☐ N
Artificial Joints	☐ Y ☐ N	Heart Murmur	☐ Y ☐ N	Sinus Trouble	☐ Y ☐ N
Asthma	☐ Y ☐ N	Heart Problems	☐ Y ☐ N	Skin Rash	☐ Y ☐ N
Back Problems	☐ Y ☐ N	Hepatitis Type___	☐ Y ☐ N	Smoker	☐ Y ☐ N
Bleeding abnormally, with		Herpes	☐ Y ☐ N	Special Diet	☐ Y ☐ N
Extractions or surgery	☐ Y ☐ N	High Blood Pressure	☐ Y ☐ N	Stroke	☐ Y ☐ N
Blood Disease	☐ Y ☐ N	Jaundice	☐ Y ☐ N	Swollen Feet or Ankles	☐ Y ☐ N
Cancer	☐ Y ☐ N	Jaw Pain	☐ Y ☐ N	Swollen Neck Glands	☐ Y ☐ N
Chemical Dependency	☐ Y ☐ N	Kidney Disease	☐ Y ☐ N	Thyroid Problems	☐ Y ☐ N
Chemotherapy	☐ Y ☐ N	Liver Disease	☐ Y ☐ N	Tonsillitis	☐ Y ☐ N
Circulatory Problems	☐ Y ☐ N	Low Blood Pressure	☐ Y ☐ N	Tuberculosis	☐ Y ☐ N
Congenital Heart Lesions	☐ Y ☐ N	Mitral Valve Prolapse	☐ Y ☐ N	Tumor or growth on head	
Cortisone Treatments	☐ Y ☐ N	Nervous Problems	☐ Y ☐ N	or neck	☐ Y ☐ N
Cough, persistent/bloody	☐ Y ☐ N	Pacemaker	☐ Y ☐ N	Ulcer	☐ Y ☐ N
Diabetes	☐ Y ☐ N	Psychiatric Care	☐ Y ☐ N	Venereal Disease	☐ Y ☐ N
Emphysema	☐ Y ☐ N	Radiation Treatment	☐ Y ☐ N	Wear contact lenses	☐ Y ☐ N

Women: Are you pregnant? ☐ Y ☐ N Due Date_____ Are you nursing? ☐ Y ☐ N

Taking birth control pills? ☐ Y ☐ N

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:_____

_____

_____

_____

Pharmacy Name_____

Phone(____)_____

ALLERGIES

☐ Aspirin
☐ Barbiturates (Sleeping Pills)
☐ Codeine
☐ Iodine
☐ Latex
☐ Local Anesthetic
☐ Penicillin
☐ Sulfa
☐ Other_____
_____

Signature of Patient, Parent, Guardian or Personal Representative _____

Please print name of Parent, Guardian, or Personal Representative _____

Christine M. Saad DDS PC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-248-693-5844.
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (248-693-5844)– رقم .: هـ مصلحة البكم او