Patient Name: _____ Date: _____

Medical Doctor: _____ Phone:_____

Date of Last Physical Exam: _____ Date of Last Dental Exam: _____

Circle One

1. Is your general health good? ..... Yes No
2. Are you having pain or discomfort at this time? ..... Yes No
3. Have you been under the continuing care of a doctor or been hospitalized for any medical condition? ..... Yes No
   If yes, what is the condition(s) you are/were being treated for?_____
   _____
4. Are you taking any medications? ..... Yes No
   If yes, please list: _____
5. Have you taken any aspirin, anti-inflammatory or pain medications within the last twelve hours?..... Yes No
   If so, when and what was the medication taken? _____
   _____
6. Are you **allergic** to **Penicillin**, **Tetracycline** or **any antibiotics**? ..... Yes No
7. Have you had an allergic reaction to any drug, medication, anesthetic or latex? ..... Yes No
8. Have you ever had any excessive bleeding requiring special treatment? ..... Yes No
9. Do you take any "blood thinning" medication such as Coumadin? ..... Yes No
10. Do you have frequent colds or sinus trouble? ..... Yes No

Doctor's Notes

Please indicate **YES** or **NO** by circling the following:

Heart Disease or Attack	Yes No	High Blood Pressure	Yes No	Anemia	Yes No	Liver Disease	Yes No
Rheumatic Fever	Yes No	Low Blood Pressure	Yes No	Bleeding Disorder	Yes No	Hepatitis A, B, C	Yes No
Mitral Valve Prolapse	Yes No	Stroke	Yes No	Blood Transfusion	Yes No	Yellow Jaundice	Yes No
Artificial Heart Valve	Yes No	Epilepsy or Seizures	Yes No	Lung Disease	Yes No	Tuberculosis (TB)	Yes No
Congenital Heart Lesion	Yes No	Scarlet Fever	Yes No	Bronchitis	Yes No	Cold Sores	Yes No
Heart Murmur	Yes No	Diabetes	Yes No	Asthma	Yes No	Psychiatric Treatment	Yes No
Heart Pace Maker	Yes No	Artificial Joint	Yes No	Hay Fever	Yes No	Drug Addiction	Yes No
Heart Surgery	Yes No	Arthritis	Yes No	Thyroid Disease	Yes No	Genital Herpes	Yes No
Angina Pectoris	Yes No	Kidney Disease	Yes No	Stomach Ulcers	Yes No		
Chemo Therapy (Cancer, Leukemia)	Yes No	Radiation Treatment of Any Kind	Yes No	(AIDS) Acquired Immune Deficiency Syndrome	Yes No	Venereal Disease (Syphilis, Gonorrhea)	Yes No

11. have you ever taken the drug Fen-Phen or Redux? ..... Yes No
12. Do you have any disease, condition, or problem not listed? ..... Yes No
13. Have you ever been diagnosed as having TMJ, TMD, Bruxism, etc? ..... Yes No
14. Do you smoke? ..... Yes No
15. **WOMEN**: Are you pregnant now? ..... Yes No
    Are you taking birth control pills? ..... Yes No

I certify that all the preceding answers are true and correct to the best of my knowledge. If I ever have any changes in my health, or if my medications change, I will inform Unique Care Endo at the next appointment without fail.

_____ _____
Signature of Patient, Parent, or Guardian Date

Doctor's Notes

_____ _____
Doctor's Signature Date

Medical History/Physical Evaluation Update

Date	Addition/Change	Patient, Parent or Guardian Signature	Staff/Doctor's Signature
_____	_____	_____	_____
_____	_____	_____	_____