GREGORY T. NASSIF, D.D.S.

Medical History

Name_____ DOB (M/D/YR)___/____/____ Today's Date_____

We understand that you are here for us to help you care for your teeth and gums. Medications you are taking and health problems you may have could make a difference in how we treat your dental problems, so this information is important. Thank you for your advanced cooperation

Have you been under the care of a medical doctor during the past two years? Yes No
If yes, for what? _____
Physician's name _____ phone _____
Address _____ City _____ State _____

Have you taken any medication or drugs during the pats two years? Yes No

Are you taking any medication or drugs currently, including regular doses of aspirin or over the counter herbal medications? Yes No
If yes, list names and dosages _____

Have you ever taken any prescription drugs for weight loss, including Fen-Phen (fenfluramine-phentermine); Pondimen (fenfluramine); and Redux (dexfenfluramine)? Yes No
If yes to the above, did you have a medical exam for heart issues? Yes No

Are you aware of having an allergic (or adverse) reaction to any medication or substance? Yes No

Have you been a patient in the hospital during the past 5 years? Yes No

Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No	Hepatitis A B C (Circle)	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S.	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	H.I.V. Positive	Yes	No
High Blood Pressure	Yes	No	Contact Lens	Yes	No	Cold Sores/Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Blood Transfusion	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	Hemophilia	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Hay Fever	Yes	No	Liver Disease	Yes	No
Cortisone Medicine	Yes	No	Latex Sensitivity	Yes	No	Yellow Jaundice	Yes	No
Swollen Ankles	Yes	No	Allergies or Hives	Yes	No	Neurological Disorders	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Epilepsy or Seizures	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Fainting Or Dizzy Spells	Yes	No
Artificial Joints (Hip, Knee, Etc.)	Yes	No	Chemotherapy	Yes	No	Nervous/Anxious	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Psychiatric/Psychologic Care	Yes	No

Do you use more than 2 pillows to sleep? Yes No

Have you gained or lost more than 10 pounds in the past year? Yes No

Do you have or have you had any disease, condition or problem not listed? Yes No

Women: Are you pregnant or think you may be pregnant? Yes, _____months No, Nursing? Yes No

Women: Do you use birth control medications? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify Dr. Nassif of any changes in my health or medication.

Patient/Guardian Signature _____ Date _____

Dentist Signature _____ Date _____