



David Lee, DDS, FAGD

Medical History

Have you been under the care of a medical doctor during the past 2 years? [] Yes [] No

If yes, for what? _____

Physician's name _____ Phone _____

Physician's City _____ State _____

Have you taken any medications or drugs in the past two years? [] Yes [] No

Are you currently taking any medications or drugs? (including regular doses of aspirin or over-the-counter medicines) [] Yes [] No

If yes, please explain _____

Have you ever taken Fen-Phen? [] Yes [] No

If so, how long ago? _____

Did you ever go to the doctor to check for heart problems? [] Yes [] No

If so, what are the problems? _____

Do you use tobacco? [] Yes [] No

Do you use alcohol or any other controlled substance? [] Yes [] No

Women only:

Are you pregnant or think you may be pregnant? [] Yes [] No Are you nursing? [] Yes [] No

Are you taking birth control pills? [] Yes [] No

Indicate which of the following you have had or have at present:

- Grid of medical conditions with Yes/No checkboxes: AIDS, Alcohol/Drug Abuse, Allergies or Hives, Arthritis/Rheumatism, Artificial Heart Valve, Artificial Bones/Joints/Valves, Asthma, Blood Transfusion, Bruise Easily, Cancer/Chemotherapy, Chest Pain, Cold Sores/Herpes, Colitis, Congenital Heart Disease, Contact Lenses, Cortisone Medicine, Chronic Cough, Diabetes, Diet (Special/Restricted), Difficulty Breathing, Emphysema, Epilepsy or Seizures, Fainting or Dizzy Spells, Frequent Headaches, Glaucoma, Hay Fever, Heart (Surgery, Disease, Attack), Heart Pacemaker, Heart Murmur, Hemophilia/Abnormal Bleeding, Hepatitis A B C (circle), High Blood Pressure, HIV Positive, Hospitalized for Any Reason, Kidney Trouble, Latex Sensitivity, Liver Disease, Low Blood Pressure, Lupus, Mitral Valve Prolapse, Nervous/Anxious, Neurological Disorders, Psychiatric/Psychological Care, Radiation Therapy, Rheumatic/Scarlet Fever, Shingles, Sickle Cell Disease/Traits, Sinus Trouble, Stroke, Swollen Ankles, Thyroid Problems, Tuberculosis (TB), Tumors, Ulcers, Venereal Disease, Yellow Jaundice.

Please list any serious medical condition(s) that you have ever had not listed above:

Are you aware of having an allergic (or adverse) reaction to any of the following:

- Grid of allergens with Yes/No checkboxes: Aspirin, Codeine, Anesthetics (for example Novocaine), Erythromycin, Iodine, Jewelry/Metals, Latex, Penicillin or Other Antibiotics, Sedatives, Sulfa Drugs, Tetracycline, Other.