Medical History Form **Bradley J. Gerdes, D.D.S.** **Phone: 414.332.6212**

Name ____ Date of Birth ______ / ______ / ______
Last First Init.

Please circle the appropriate answer. If you don't know the correct answer, please write "Don't Know" on the line after the question.
If you answer yes, and there is an arrow to the right ("YES >"), please add any appropriate explanation in the comment box to the right.
Thank you for your help.

				COMMENTS
1.	Physician's Name: City and Phone Number (If known):	NO	YES	
2.	Are you currently under a physician's care? For what condition?	NO	YES	
3.	When was your last complete physical examination?			
4.	Are you taking any medication or substances? If yes, please list medications in the comments box at right.	NO	YES >	
5.	Do you routinely take health related substances? (vitamins, herbal supplements, natural products)	NO	YES	
6.	Are you allergic to any medications or substances? If yes, please explain at right.	NO	YES >	
7.	Do you have any other allergies or hives?	NO	YES	
8.	Do you have any problems with penicillin, antibiotics, anesthetics, or other medications?	NO	YES	
9.	Are you sensitive to any metals or latex?	NO	YES	
10.	Are you pregnant, or suspect that you may be?	NO	YES	
11.	Do you use any birth control medications?	NO	YES	
12.	Have you ever been treated for or been told you might have heart disease?	NO	YES >	
13.	Do you have a pacemaker, an artificial heart valve implant, or been diagnosed with mitral valve prolapse?	NO	YES	
14.	Have you ever had rheumatic fever?	NO	YES	
15.	Are you aware of any heart murmurs?	NO	YES	
16.	Do you have high or low blood pressure? (Please circle)	NO	YES	
17.	Have you ever had a serious illness or major surgery? If so, please explain in the box at right.	NO	YES >	
18.	Have you ever had radiation treatment or chemotherapy?	NO	YES >	
19.	Do you have inflammatory diseases, such as arthritis or rheumatism?	NO	YES	
20.	Have you ever taken Fosamax, Zometa, Aredia or any other oral or intravenous treatment (bisphosponates) for bone tumors, excessive calcium in your blood or osteoporosis?	NO	YES	
21.	Do you have any artificial joints or prosthesis? Year placed:	NO	YES	
22.	Do you have any blood disorders, such as anemia, leukemia, etc.?	NO	YES >	
23.	Have you ever bled excessively after being cut or injured?	NO	YES	
24.	Do you have any stomach problems?	NO	YES >	
25.	Do you have any kidney problems?	NO	YES >	
26.	Do you have any liver problems?	NO	YES >	
27.	Are you diabetic? What type? How long?	NO	YES	
28.	Do you have asthma?	NO	YES	
29.	Do you have epilepsy or seizure disorders?	NO	YES	
30.	Do you or have you had a venereal disease?	NO	YES	
31.	Have you ever tested positive to HIV infection or AIDS?	NO	YES	
32.	Have you ever tested positive for hepatitis (other than hepatitis A)?	NO	YES	
33.	Do you or have you had T.B.?	NO	YES	
34.	Do you smoke, chew, use snuff, or any other form of tobacco?	NO	YES	
35.	Do you regularly consume more than one or two alcoholic beverages a day?	NO	YES	
36.	Do you habitually use controlled substances, especially cocaine?	NO	YES	
37.	Have you had psychiatric treatment?	NO	YES	
38.	Have you taken the prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dextenfluramine (redux), or other weight loss products?	NO	YES	
39.	Would you like to speak to Dr. Gerdes in private about any problem?	NO	YES	
40.	Do you have any disease, condition, or problem not listed? If so, please explain in box at right.	NO	YES >	
41.	Is there anything else we should know about your health that we have not covered in this form? If so, please explain here or in box at right.	NO	YES >	

I certify that the above information is complete and accurate.

Name ____ Date ______ / ______ / ______