Medical History

*** Please complete the following medical history form as accurately and thoroughly as possible. ***

Section 1

Patient Name: _____ Date of Birth: _____

- Who is your Primary Care physician? _____
- Are you being treated by another physician for any medical conditions, such as diabetes, heart conditions, etc..?
  YES [ ] NO [ ]
  - If yes, who and for what?_____
- Have you ever been hospitalized or had a major operation? YES [ ] NO [ ]
  - If yes, _____
- Have you ever had a serious head or neck injury? YES [ ] NO [ ]
  - If yes, _____
- Are you currently taking any medication, pills or drugs? YES [ ] NO [ ]
  - If yes, _____
    _____
- Have you ever taken Fosamax, Boniva, Actonel, or any other medication containing bisphosphonates?
  YES [ ] NO [ ]
  - If yes, _____
- Do you have any heart conditions? YES [ ] NO [ ]
- Do you take a premedication prior to dental procedures? YES [ ] NO [ ]
- Do you use tobacco? YES [ ] NO [ ]

Section 2

Women: Are you….

Pregnant?	YES [ ]	NO [ ]
Nursing?	YES [ ]	NO [ ]
Taking oral contraceptives?	YES [ ]	NO [ ]

Are you allergic to any of the following? :

Aspirin?	YES [ ]	NO [ ]
Metal?	YES [ ]	NO [ ]
Penicillin?	YES [ ]	NO [ ]
Latex?	YES [ ]	NO [ ]
Codeine?	YES [ ]	NO [ ]
Sulfa Drugs?	YES [ ]	NO [ ]
Acrylic?	YES [ ]	NO [ ]
Local Anesthetics?	YES [ ]	NO [ ]

Other? If yes _____

Section 3

Do you have, or have you had, any of the following? Circle those that apply.

AIDS/HIV POSITIVE DIABETES RENAL DIALYSIS ASTHMA STROKE VENEREAL DISEASE HIGH BLOOD PRESSURE SHINGLES HIGH CHOLESTEROL CHEST PAINS CORTISONE MEDICINE ULCERS FREQUENT COUGH STOMACH/INTESTINAL ISSUES ANEMIA SPINA BIFIDA COLD SORES/FEVER BLISTERS LOW BLOOD PRESSURE CHEMOTHERAPY CANCER HEPATITIS A,B, OR C RHEUMATISM ARTIFICAL HEART VALVE TUBERCULOSIS ARTIFICAL JOINT FAINTING/DIZZY SPELLS KIDNEY ISSUES HIVES/RASH FREQUENT HEADACHES PAIN IN JAW JOINTS HEART DISEASE/DISORDER RADIATION TREATMENTS EASILY WINDED ANAPHYLAXIS ARTRITIS/GOUT EXCESSIVE BLEEDING EXCESSIVE THIRST SINUS/BREATHING TROUBLE LUNG DISEASE LIVER DISEASE/JAUNDICE OSTEOPOROSIS TUMORS/GROWTHS PSYCHIATRIC CARE ALZHEIMER'S DISEASE DRUG ADDICTION EPILEPSY/SEIZURES EMPHYSEMA/COPD HEART PACEMAKER HYPOGLYCEMIA BLOOD DISEASE BLOOD TRANSFUSION THYROID DISEASE

Have you ever had any serious conditions that are not listed above? YES [ ] NO [ ]

If yes, _____

Signature: _____ Date: _____