MEDICAL HISTORY

Patient Name _____

Physician's Name _____ Phone _____

Have you had any medical care within the past two years? ..... Yes No

Describe _____

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

If yes please list name and dosage _____

Have you ever taken bone loss prevention drugs such as Fosamax, Boniva, or other bisphosphonates? ..... Yes No

If yes please list name and dosage _____

Are you currently taking blood thinners and or regular doses of aspirin? ..... Yes No

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

If yes, please specify _____

Have you been a patient in the hospital in the past five years? ..... Yes No

Please indicate which of the following you have had or have presently. Circle YES to all those that apply

Heart attack, disease, surgery ..Yes	Ulcers ..... Yes	Hepatitis A B C ..... Yes
Chest Pain ..... Yes	Diabetes .....Yes	Venereal Disease ..... Yes
Congenital Heart Disease ..... Yes Yes	Thyroid Problems .....Yes	A.I.D.S/H.I.V. positive ....
Heart Murmur ..... Yes	Glaucoma ..... Yes	Cold Sores/Fever Blisters..Yes
High/low Blood Pressure ..... Yes	Contact Lenses .....Yes	Blood Transfusion ..... Yes
Mitral Valve Prolapse .....Yes	Emphysema .....Yes	Hemophilia ..... Yes
Artificial Valve/Pacemaker .....Yes	Chronic Cough .....Yes	Sickle Cell Disease ..... Yes
Rheumatic Fever ..... Yes	Tuberculosis .....Yes	Bruise Easily ..... Yes
Arthritis/Rheumatism ..... Yes	Asthma ..... Yes	Liver Disease/Jaundice .... Yes
Anorexia .Bulimia ..... Yes	Hay Fever/Allergies ... .Yes	Neurological Disorder ..... Yes
Swollen Ankles ..... Yes	Latex Sensitivity ..... Yes	Epilepsy/Seizures ..... Yes
Stroke .....Yes	Sinus Trouble ..... Yes	Fainting/Dizzy Spells .....Yes
Diet/special restricted ..... Yes	Radiation Therapy ..... Yes	Dry Mouth .....Yes
Artificial Joints hip, knee etc .....Yes	Chemotherapy..... Yes	Psychological care ..... Yes
Kidney Trouble .....Yes	Tumors ..... Yes	Cancer ..... Yes

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

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

Women: Are you pregnant or think you could be pregnant? Yes _____ Months _____ Nursing? Yes No

MEDICAL HISTORY

Patient Name _____

I understand the 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 the doctor of any change in my health or medication.

_____

___ Responsible Party Signature Date