# 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 | Thyroid Problems .....Yes | A.I.D.S/H.I.V. positive .... Yes |
| 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

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