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Medical History

Patient Name: _____

Name of Medical physician: _____

Phone # of Medical physician: _____

Would you consider yourself to be in fairly good health? * ◯ Yes ◯ No

Are you currently under the care of a physician due to a specific condition? * ◯ Yes ◯ No

Have you been hospitalized within the last 5 years due to a surgery or illness? * ◯ Yes ◯ No

If yes, please explain:

_____

_____

Within the past year, have there been any changes in your general health? if yes please specify

_____

_____

What is the date or approx. date of your last medical exam * _____

Have you lost or gained more than 10 pounds in the last year? * ◯ Yes ◯ No

Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? Please circle which one (s).

If yes, please list.

_____

_____

Please check the box if you have been diagnosed with any of the following or had an allergic reaction to any medication listed below?

- ☐ Acid Reflux
- ☐ Arthritis
- ☐ Birthcontrol
- ☐ Ceclor
- ☐ Diabetes
- ☐ Excessive Bleeding
- ☐ Hearing Impairment
- ☐ High Blood Pressure
- ☐ Latex
- ☐ MS
- ☐ Other
- ☐ Pregnancy
- ☐ Respiratory Problems
- ☐ Stent
- ☐ Tuberculosis
- ☐ xOther Explain Below
- ☐ Aids/HIV+
- ☐ Artificial Joints
- ☐ botox
- ☐ Codeine
- ☐ Dizziness
- ☐ Fainting
- ☐ Heart Disease
- ☐ Hypothyroidism
- ☐ Lichen Planus
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pre-Med Amox.
- ☐ Rheumatic Fever
- ☐ Stomach Problems
- ☐ Tumors
- ☐ Anemia
- ☐ Aspirin
- ☐ Bulimia
- ☐ Coronary By-pass
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart Murmur
- ☐ Jaundice
- ☐ Liver Disease
- ☐ No Electrosurge
- ☐ Penicillin
- ☐ Pre-Med Clinda
- ☐ Rheumatism
- ☐ Stroke
- ☐ Ulcers
- ☐ Arestin
- ☐ Asthma
- ☐ Cancer
- ☐ Dental Phobic
- ☐ Epstein Barr Virus
- ☐ Hay Fever
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ MEDS; High Blood Pre
- ☐ No Epinephrine
- ☐ peroxide
- ☐ Radiation Therapy
- ☐ Sinus Problems
- ☐ sulfa
- ☐ Valve Replacment

Have you had an allergic reaction to any medication? Please List *

_____

_____

Please check the box(boxes) below that are applicable to you: *

- ☐ Blood Transfusion
- ☐ Bruise Easily
- ☐ Chemotherapy
- ☐ Chest Pain
- ☐ Chronic Cough
- ☐ Congenital Heart Disease
- ☐ Cortisone Medicine
- ☐ Diet (restricted)
- ☐ Emphysema
- ☐ Hemophilia
- ☐ Mitral Valve Prolapse
- ☐ Neurological Disorders
- ☐ Psychiatric / Psychological Care
- ☐ Sickle Cell Disease
- ☐ Swollen Ankles
- ☐ Thyroid Problems
- ☐ OTHER: _____
- ☐ NONE

If you are currently taking any prescription or non-prescription medications?Please list:

_____

_____

Have you ever taken prescription medication for weight loss (diet pills)? If you have not taken any of the prescription listed or OTHER, please select NONE *

☐ Fen_phen ☐ Pondimen ☐ Redux ☐ Other ☐ NONE

Do you have any disease, conditions or problem not listed?

_____

_____

Please Check off if you are taking any of the listed medications. please select NONE OF THESE. *

- ☐ Asprin
- ☐ Bisphosphonate
- ☐ Chemotherapy
- ☐ Coumadin
- ☐ High Blood Pressure Medicine
- ☐ NONE OF THESE

Do you wear contact lenses? * ◯ Yes ◯ No

WOMAN - Are you or could you be pregnant? * ◯ Yes ◯ No

☐ ***I understand that the above 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.**

By checking this box I acknowledge that I have read all statements above and affirm the contents.

Please sign and date below

Signature _____

Date _____

Response Date: _____