Fisher & Orfaly
DENTAL

MEDICAL HISTORY

Patient's Full Name: _____

Do you see your physician regularly? Yes _____ No _____ Are you in good health? Yes _____ No _____

Are you taking or have you recently taken any prescription or over-the-counter medicine(s)? Yes _____ No _____

If so, please list: _____

_____

Are you allergic to any medications? Yes _____ No _____ If so, please list _____

Do you have a latex allergy? Yes _____ No _____

Have you had an orthopedic joint replacement? Yes _____ No _____ If so, please provide date _____

Are you taking or scheduled to begin taking any medications for osteoporosis? Yes _____ No _____

Are you pregnant? Yes _____ No _____

PLEASE CHECK IF YOU HAVE/HAD ANY OF THE FOLLOWING CONDITIONS

Artificial Heart Valve	____	Asthma	____	Acid Reflux	____
Infective Endocarditis	____	Tuberculosis	____	Hepatitis	____
Congenital Heart Disease	____	Cancer	____	Osteoporosis	____
Cardiovascular Disease	____	Angina	____	Kidney Problems	____
AIDS or HIV infection	____	Heart Attack	____	Eating Disorder	____
Autoimmune Disease	____	Rheumatic Fever	____	Diabetes	____
High Blood Pressure	____	Bleeding Disorder	____	Migraines	____

Do you have any condition not listed above that you think we should know about? Yes _____ No _____

If so, please explain _____

_____ _____

Patient Signature or Legal Guardian (if patient is under age of 18) Date