MEDICAL HISTORY

Name: _____

Today's Date: _____

Birth Date: _____

Are you under a physician's care now? If yes, _____.

Have you ever been hospitalized or had a major operation? If yes,
_____.

Have you ever had a serious head or neck injury? If yes,
_____.

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? _____.

Do you use tobacco? _____
Do you use controlled substances?_____

WOMEN:
Are you…
Pregnant? Y/N Nursing? Y/N Taking oral contraceptives? Y/N

ALLERGIES:
Are you allergic to any of the following:

Aspirin	Penicillin	Codeine	Acrylic
Metal	Latex	Sulfa Drugs	Local Anesthetics

List any other allergies:_____

MEDICATIONS:
Please list all medications that you are currently taking:

Do you have, or have you had, any of the following? (Circle all that apply)

AIDS/HIV Positive	Cortisone Medicine	Hemophilia	Radiation Treatments
Alzheimer's Disease	Diabetes	Hepatitis A	Recent Weight Loss
Anaphylaxis	Drug Addiction	Hepatitis B or C	Renal Dialysis
Anemia	Easily Winded	Herpes	Rheumatic Fever
Arthritis/Gout	Emphysema	High Blood Pressure	Rheumatism
Artificial Heart Valve	Epilepsy or Seizures	High Cholesterol	Scarlet Fever
Artificial Joint	Excessive Bleeding	Hives or Rash	Shingles
Asthma	Excessive Thirst	Hypoglycemia	Sickle Cell Disease
Blood Disease	Fainting Spells / Dizziness	Irregular Heartbeat	Sinus Trouble
Blood Transfusion	Frequent Cough	Kidney Problems	Spina Bifida
Breathing Problems	Frequent Diarrhea	Leukemia	Stomach/Intestinal Disease
Bruise Easily	Frequent Headaches	Liver Disease	Stroke
Cancer	Genital Herpes	Low Blood Pressure	Swelling of Limbs
Chemotherapy	Glaucoma	Lung Disease	Thyroid Disease
Chest Pains	Hay Fever	Mitral Valve Prolapse	Tonsilitis
Cold Sores/Fever Blisters	Heart Attack/Failure	Osteoporosis	Tuberculosis
Congenital Heart Disorder	Heart Murmur	Pain in Jaw Joints	Tumors or Growths
Convulsions	Heart Pacemaker	Parathyroid Disease	Ulcers
	Heart Trouble/Disease	Psychiatric Care	Venereal Disease

Have you ever had any serious illness not listed above? _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

Patient Signature