MEDICAL HISTORY

Patient Name

1. Have you been under the care of a medical doctor during the past two years? YES NO

   If yes, for what? ______________________________

   Physician's Name ______________________ Phone ______________

2. Are you taking medications drugs, or pills now, including regular dosages of aspirin or herbal supplements? YES NO

   If yes, please list name and dosage ______________________________

   ____

3. Are you aware of having an allergic (or adverse) reaction to any medication or substance? YES NO

   If yes, please list ______________________________

4. Please check any of the following that you have had, or have presently:

- ☐ Heart Disease/Attack/Surgery
- ☐ Asthma
- ☐ Hepatitis A
- ☐ Bacterial Endocarditis
- ☐ Tuberculosis
- ☐ Hepatitis B
- ☐ Congenital Heart Disease
- ☐ Emphysema
- ☐ Hepatitis C
- ☐ Artificial Heart Valve
- ☐ Sinus Trouble
- ☐ Diet (Special)
- ☐ High Blood Pressure
- ☐ Neurological Disorders
- ☐ Ulcers
- ☐ Heart Pacemaker
- ☐ Epilepsy/Seizures
- ☐ Tumors
- ☐ Chest Pain
- ☐ Nervous/Anxious
- ☐ Radiation Therapy
- ☐ Stroke
- ☐ Psychiatric/Psychological
- ☐ Chemotherapy
- ☐ Blood Disorders
- ☐ Glaucoma
- ☐ Arthritis/Rheumatism
- ☐ H.I.V Positive
- ☐ Kidney Trouble
- ☐ Artificial Joints
- ☐ A.I.D.S
- ☐ Diabetes
- ☐ Cold Sores/Fever Blisters
- ☐ Hemophilia
- ☐ Thyroid Problems
- ☐ Allergies or Hives
- ☐ Bruise Easily
- ☐ Liver Disease
- ☐ Latex Sensitivity

5. Do you have or have you had any disease, condition, or problem not listed? YES NO

   If yes, please list: ______________________________

6. Do you smoke or chew tobacco? YES NO ________ packs/day

7. Are you currently or have you ever taken any of the following: (please circle)

   Fosomax Fosomax Plus D Actonel Boniva Zometa Aredia Prolia Other______________

8. Women. Are you: *Pregnant ?* YES (____ months) NO *Nursing?* YES NO *Taking birth control pills?* YES NO

I understand 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 may 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.

Patient/Guardian Signature ______________________ Date ______________

For office use only: History Review

Dentist Signature ______________________ Date ______________