



**MEDICAL HISTORY**

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ DATE: \_\_\_\_\_

Are you now under the care of a physician? Yes  No

If yes, for what reason \_\_\_\_\_  
 Physician's Name: \_\_\_\_\_

Are you allergic to any medication or substances? Yes  No

If yes, please list \_\_\_\_\_

Have you ever had a serious accident, hospitalization, or major operation? Yes  No

If yes, please explain: \_\_\_\_\_

Have you ever taken Fosamax, Boniva, or any other bisphosphonate drug? Yes  No

Do you currently smoke or use the following tobacco products? Yes  No

Cigarettes     Cigars     Pipe     Chew     None

If so, how much? \_\_\_\_\_

Are you interested in quitting at this time?

Have you ever been told that you need antibiotics before dental treatment? Yes  No

Would you like to speak to the Doctor privately about any problem? Yes  No

**WOMEN:** Are you pregnant or trying to get pregnant? Yes  No

Are you nursing? Yes  No

Do you take any birth control medications? Yes  No

Do you have, or have you had any of the following: (**check yes or no**)

	Yes	No		Yes	No		Yes	No
Heart Disease/Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Dementia	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	High/Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valve	<input type="checkbox"/>	<input type="checkbox"/>	STD/STI	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	HIV positive/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Prosthetic Implants	<input type="checkbox"/>	<input type="checkbox"/>
Learning disability	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol addiction	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joint	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric care	<input type="checkbox"/>	<input type="checkbox"/>	Drug dependency	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>
Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	Chemical dependency	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis (circle one)	<input type="checkbox"/>	<input type="checkbox"/>
Bulimia	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Type    A    B    C		
Lung disease	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Stomach disorder	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	GERD (gastric reflux)	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Impaired	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory Ailments	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell disease	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone Medicine	<input type="checkbox"/>	<input type="checkbox"/>
Heart pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Organ Transplant	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disorder	<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	(ex. Fibromyalgia, Lupus)					

Have you had any other illness/condition not checked above? Yes  No

If yes, please describe \_\_\_\_\_

**CURRENT MEDICATIONS**

Please list any medications including vitamins, herbal supplements, or over-the-counter drugs taken:

<b><u>MEDICATION NAME</u></b>	<b><u>USE</u></b>

**DOCTOR COMMENTS:**

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 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 changes in my health or medication.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_  
(PARENT/GUARDIAN OF A MINOR)

Doctor Signature \_\_\_\_\_ Date \_\_\_\_\_