MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____Today's Date_____

Are you under a physician's care now? Yes No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____

Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____

Do you take, or have you taken, bisphosphonates? Yes No

Do you use nicotine? Yes No

Are you taking any medications, pills, or drugs? Yes No If yes, please list: _____

_____

_____

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain:_____

Please circle if you have or have ever had any of the following

AIDS/HIV Positive	Diabetes	Hypoglycemia	Rheumatism
Alzheimer's Disease	Drug Addiction	Irregular Heartbeat	Scarlet Fever
Anemia/Blood Disorder	Emphysema	Kidney Problems	Shingles
Angina	Epilepsy or Seizures	Leukemia	Sickle Cell Disease
Arthritis/Gout	Excessive Bleeding	Liver Disease	Sinus Trouble
Artificial Heart Valve	Fainting Spells/Dizziness	Low Blood Pressure	Stomach/Intestinal Disease
Artificial Joint	Frequent Headaches	Lung Disease	Stroke
Asthma	Heart Attack/Failure	Mitral Valve Prolapse	Swelling of Limbs
Breathing Problem	Heart Murmur	Osteoporosis	Thyroid Disease
Bruise Easily	Heart Pace Maker	Pain in Jaw Joint	Tonsillitis
Cancer	Heart Trouble/Disease	Parathyroid Disease	Tuberculosis
Chemotherapy	Hemophilia	Psychiatric Care	Tumors or Growths
Cold Sores/Fever Blisters	Hepatitis A, B, C	Radiation Treatments	Ulcers
Congenital Heart Disorder	High Blood Pressure	Renal Dialysis	Venereal Disease
Cortisone Medicine	High Cholesterol	Rheumatic Fever	Yellow Jaundice

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

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.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____