MEDICAL HISTORY

Patient Name____ Date of Birth______________________

1. Physician's Name ____
2. Are you under a Physician's care for any conditions besides routine care?…….. YES NO
3. When was your last physical exam? ____
4. Are you taking any medication or supplements? List here or provide a list:

   ____

   ____

   ____
5. Are you allergic to any medications or have any problems with any medications? List here:

   ____
6. Do you have any other allergies? List here: YES NO

   ____
7. Do you have any problems with anesthetics?……………………………………..YES NO
8. Are you sensitive to metals or latex? …………………………………………..YES NO
9. (Women) Are you pregnant or suspect you may be?…………………………...YES NO
10. (Women) Do you use any birth control medications?…………………………YES NO
11. Have you ever been treated for or been told you might have heart disease?…….YES NO
12. Do you have a pacemaker or artificial heart valve?…………………………...YES NO
13. Do you have high or low blood pressure? (circle which one)…………………...YES NO
14. Have you ever had a serious illness or major surgery? List here: YES NO

    ____
15. Have you ever had radiation treatment or chemotherapy?………………………..YES NO
16. Have you ever taken bisphosphonates (Fosamax, Zometa, Aredia) or any other oral or IV treatment for bone tumors, excessive calcium in your blood or osteoporosis?…… …YES NO
17. Do you have inflammatory diseases, such as arthritis or rheumatism?………… YES NO
18. Do you have any artificial joints/prosthesis?……………………………………YES NO
19. Do you have any blood disorders, such as anemia, leukemia, etc?……………… YES NO
20. Have you ever bled excessively after being cut or injured?……………………… YES NO
21. Do you have any stomach, kidney or liver problems? (circle which one)…………YES NO
22. Are you diabetic?………………………………………………………………… YES NO
23. Do you have fainting or dizzy spells?…………………………………………… YES NO
24. Do you have asthma?……………………………………………………………YES NO
25. Do you have epilepsy or seizure disorders?…………………………………….. YES NO
26. Do you or have you had a sexually transmitted disease?……………………….. YES NO
27. Do you have AIDS or have you tested HIV positive?……………………………. YES NO
28. Have you had or do you test positive for hepatitis?……………………………… YES NO
29. Do you or have you had T.B. (tuberculosis)?…………………………………….. YES NO
30. Do you smoke, chew tobacco, use snuff or any forms of tobacco?……………… YES NO
31. Do you use any forms of drugs?…………………………………………………YES NO
32. Do you regularly consume more than one or two alcoholic beverages a day?…… YES NO
33. Have you ever had psychiatric treatment or been treated for a mental illness?….. YES NO
34. Do you have any disease or condition not listed? If so, explain:

    ____

Comments:

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S/GUARDIAN'S SIGNATURE ___________________________________DATE: ______________

DENTIST'S SIGNATURE ____DATE: ______________