MEDICAL HISTORY

NAME: ______________________________ **Birth Date:** __________ **Special Alerts:** ______________

1. Physician's Name: ______________________________ Date of Last Exam: ______________
   Physician location: ______________________________ Office Phone: ______________
2. Are you Under Medical Treatment now? Y/N Please explain ______________________________
3. Have you ever been hospitalized, had a serious illness or had a major operation? Y/N
   Please explain: ______________________________
4. Have you ever had a serious head or neck injury? Y/N Please explain: ______________________________
5. Please list any medications you are taking: ______________________________
   ____
6. Have you ever taken Bisphosphonates? Y/N Please explain: ______________________________
   (Such as: Fosamax, Boniva, Actonel, Aredia, Reclast, Zometa or any other medications contaning bisphosphonates)
7. Do you take, or have you taken, Phen-Fen or Redux? Y/N If Yes, how long ___ & have you seen a cardiologist? Y/N
8. Do you use tobacco? Y/N If Yes, What Kind? ______________ How Often? _______ How Long? _______
9. Do you use controlled substances? Y/N Please explain: ______________________________
10. Women Only: Are you Pregnant/Trying to get pregnant? Y/N Nursing? Y/N Taking Oral Contraceptives? Y/N
11. Have you ever had any difficult extractions or prolonged bleeding in the past? Y/N
12. **Are you allergic to or have you had any reactions to the following?**

Penicillin **Aspirin** **Latex Rubber** **Local Anesthetics** **Barbiturates or Sedatives**
Other Antibiotics **Codiene** **Metal or Acrylic** **Sulfa Drugs** **Iodine**

Other Allergy? Please List ______________________________

13. Do you have or have you had any of the following?

	Y	N		Y	N		Y	N
Artificial Joint			Breathing/Respitory Problems			Seizures, Epilepsy, Convulsions		
Date Placed:			Seasonal Allergies/Hay Fever			Dizziness/Fainting Spells		
Heart Disease/Trouble			Anaphlaxis			Diabetes		
Heart Attack/Failure			Asthma			HbA1c:		
Artificial heart Valve			Do you carry an inhaler?			Hypoglycemia		
Congenital Heart Disorder			Sinus Trouble			High Cholesterol		
High Blood Pressure			Lung Disease/COPD/Emphysema			Shingles		
Low Blood Pressure			Tuberculosis			Glaucoma		
Heart Pace Maker			Blood Disease			Stomach/Intestinal Disease		
Angina/Chest pains			Anemia			Ulcers		
Irregular Heartbeat/Afib			Hemophilia			Parathyroid Disease		
Mitral Valve Prolapse			Sickle Cell Disease			Thyroid Disease		
Easily Winded			Blood Transfusion			Liver Disease		
Swelling of Limbs			HIV /AIDS			Hepatitis A		
Stroke			Bruise Easily			Hepatitis B or C		
Rheumatic or Scarlet Fever			Prolonged bleeding			Jaundice		
Arthritis/Rheumatism/Gout			Alzheimer's Disease			Kidney Disease		
Osteoporosis (Bisphosponates?)			Dementia			Renal Dialysis		
Cancer			Psychiatric Care			Drug Addiction		
Leukemia			Cognitive Impairment			CPAP/Sleep Apnea		
Chemotherapy			TMJ			Dry Mouth/Excessive Thrist		
Radiation			Frequent Headaches			Cold Sore/Fever Blisters/Herpes		
Tumors or Growths			Cortisone Medicine					

Comments: ______________________________

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

Signature of Patient, Parent or Guardian: ______________________________ Date: __________