Medical History

Name _____ **Date of Birth:** _____ **Phone #** _____ **Home / Cell**

Address: _____ **Email** _____

Physician's Name _____ **Phone #**_____ **Date of last visit** _____

Have you been under the care of a physician in the last two years? ____yes ____no

If so, for what?_____

Are you taking any medications at this time? (List Below or Attach Copy of List) ____yes ____no

a)_____ c)_____ e)_____

b)_____ d)_____ f)_____

Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? ____ yes ____ no

Have you ever had any serious injury or surgery? ____yes ____no

If so, for what?_____

Do you have any artificial limbs, joints or heart valve prosthesis? (List Below) ____yes ____no

a)_____ date _____ c)_____ date _____

b)_____ date _____ d)_____ date _____

Has your physician told you that you need to be pre-medicated with an antibiotic for dental work? ____yes ____no

Do you have or have you ever had any of the following: (please circle)

Heart Attack	yes / no	Hepatitis A __ B __ C __	yes / no	**Are you allergic to:**
Congestive Heart Failure	yes / no	Jaundice	yes / no	
Heart Surgery	yes / no	Liver Disease	yes / no	___ Local anesthetics
Heart Murmur	yes / no	Drug Addiction	yes / no	___ Penicillin
Cardiac Pacemaker	yes / no	HIV	yes / no	___ Sulfa drugs
High Blood Pressure	yes / no	Kidney Disease	yes / no	___ Barbiturates
Low Blood Pressure	yes / no	Persistent Cough	yes / no	___ Sedatives
Stroke	yes / no	Emphysema / COPD	yes / no	___ Sleeping pills
Cancer _____	yes / no	Sinus Trouble	yes / no	___ Pain relievers
Shortness of Breath	yes / no	Tuberculosis	yes / no	___ Latex
Stomach Ulcers	yes / no	Asthma	yes / no	___ Food Allergies
Glaucoma	yes / no	Autism	yes / no	___ Other Antibiotics (List Below)
Diabetes (Type I __ Type II __)	yes / no	Epilepsy / Seizures	yes / no	
Fainting Spells	yes / no	Arthritis	yes / no	Other: _____
Dizziness	yes / no	Alcoholism	yes / no	_____
Anemia	yes / no	Thyroid Disease	yes / no	
Sleep Apnea	yes / no	Parkinson's Disease	yes / no	Do you chew tobacco? ____ yes ____ no
Mental Health Disorder (specify)	yes / no	Asperger's	yes / no	Do you smoke? ____ yes ____ no

_____

Women Only: Are you pregnant? _____ yes _____ no Are you nursing? _____ yes _____ no

Please note any disease, condition or problems not listed above:

_____

_____

I HAVE ANSWERED THE ABOVE QUESTIONS TRUTHFULLY AND TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO KEEP MY DENTIST AND HIS STAFF AWARE OF ANY CHANGES IN MY HEALTH OR MEDICATIONS AND I AGREE TO DO SO. I FURTHER AGREE TO HOLD HARMLESS THE DENTIST OR HIS STAFF IN ANY EVENT CAUSED BY EITHER MY FAILURE TO DO SO, OR BY ANY ERROR OF OMISSION OR COMMISSION ON MY PART.

_____ _____

Signature (if other than patient, specify relationship) Date