Medical History

Patient's Name ____ Birth Date ___________

Date of last physical exam: ____
Are you currently under a physician's care? Yes No If yes: __________________________
Have you been hospitalized/had major surgery? Yes No If yes:__________________________
Have you ever had serious head/neck injury? Yes No
If yes:___________________________

Are you taking any medications or drugs (including herbal supplements)? Please list type and dosage:
____
____

Have you ever been treated with Fosamax, Aredia, Zometa, Actonel, Boniva, Reclast or Prolia or any other Bisphosphonate drug? Yes No If Yes:____
Do you take or have you taken Phen-Fen or Redux? Yes No If yes:________________________

Are you taking any of these medications? (Please select "Yes" or "No")

Pre-medication before dental treatment?	Yes	No	Tagamet (Omeprazole)?	Yes	No
Antacids?	Yes	No	Cardizem (Verapamil)?	Yes	No
St. John's Wort or Kava-Kava?	Yes	No	Serzone	Yes	No
Dilantin	Yes	No	Diflucan (Itraconazole)	Yes	No
Barbiturates (any)	Yes	No	Biaxin®	Yes	No
Do you consume grapefruit juice, grapefruits or grapefruit extract?				Yes	No

For Women: Are you
▫ Pregnant/trying to get pregnant? ▫ Nursing? ▫ Taking Oral Contraceptives?

Are you allergic to any of the following?
▫ Aspirin ▫ Penicillin ▫ Codeine ▫ Acrylic
▫ Metals ▫ Latex ▫ Sulfa Drugs ▫ Local Anesthetics
▫ Other Allergies If Yes:____

Do you use tobacco products? Yes No If yes, how often? ___________________________
Do you consume alcohol? Yes No If yes, how often? ___________________________
Do you use controlled substances? Yes No Please explain? ___________________________
Are you on a special diet? Yes No Please explain? ___________________________

Health Conditions: (Please indicate by circling "Yes" or "No")

Condition			Condition			Condition			Condition		
AIDS/HIV Positive	Yes	No	Cortisone Medication	Yes	No	Hemophilia	Yes	No	Radiation Treatment	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Recent Weight loss	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Renal Dialysis	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Rheumatic Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Rheumatism	Yes	No
Arthritis/Gout	Yes	No	Epilepsy/Seizure	Yes	No	High Cholesterol	Yes	No	Scarlet Fever	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hives or Rash	Yes	No	Shingles	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Hypoglycemia	Yes	No	Sickle Cell Disease	Yes	No
Asthma	Yes	No	Fainting Spell/ Dizziness	Yes	No	Irregular Heartbeat	Yes	No	Sinus Trouble	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Kidney Problems	Yes	No	Spina Bifida	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Leukemia	Yes	No	Stomach/ Intestinal Ds	Yes	No
Breathing Problems	Yes	No	Frequent Headaches	Yes	No	Liver Disease	Yes	No	Stroke	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Low Blood Pressure	Yes	No	Swelling of limbs	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Lung Disease/ COPD	Yes	No	Thyroid Disease	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Mitral Valve Prolapse	Yes	No	Tonsillitis	Yes	No
Chest Pains	Yes	No	Heart Attack/ Failure	Yes	No	Osteoporosis	Yes	No	Tuberculosis	Yes	No
Cold Sores/ Fever Blisters	Yes	No	Heart Murmur	Yes	No	Pain in Jaw Joints	Yes	No	Tumors/ Growths	Yes	No
Congenital Heart Disease	Yes	No	Heart Pacemaker	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Convulsions	Yes	No	Heart Trouble/ Disease	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Yellow Jaundice	Yes	No									

Have you had any serious illness not listed? Yes No If yes:______________________________

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/Guardian Date