MEDICAL HISTORY

A thorough knowledge of your general health will enable us to provide you with the highest quality of dental care.

Name ____ Date ________________________________

Is your physical health good ____ Fair______ Poor______ Date of Last Physical Exam_____________________

Medical Doctors Name and Phone number____

Any changes in your health in the past year: Yes ______ No______ Explain________________________________

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Have you ever had, or currently have, the following:

Y N Cancer: Multiple Myeloma____ Metastatic Breast ______ Lung ____ Prostate ____ Other ___________

Y N Radiation Therapy	Y N Thyroid Disease	Y N Stomach Ulcer
Y N Heart Trouble	Y N Lung Problems	Y N Psychiatric Therapy
Y N Heart Attack	Y N Asthma	Y N Depression
Y N Heart Murmur	Y N Continuing Cough	Y N Stress/ Anxiety
Y N Rheumatic Heart Condition	Y N Tuberculosis	Y N Seizures /Epilepsy
Y N High Blood Pressure	Y N Stroke	Y N Sexually Transmitted Disease
Y N Low Blood Pressure	Y N Fainting/ Dizziness	Y N HIV /AIDS
Y N Frequent headaches	Y N Liver Disorder/Jaundice	Y N Kidney Disease
Y N Diabetes	Y N Hepatitis	Y N Arthritis
Y N Anemia	Y N Blood Disorder or Abnormal Bleeding ______________________________	

Do You have any Implants such as heart valve, stent, pacemaker, or joint replacement ____________________

Any disease, problem, or prolonged illness not listed, that I should know about? Yes ____ No _____

If so, please explain____

Family medical history Includes ___ Diabetes ___ Heart Disease Other ___________________________________

Please Explain: ____

Women Patients:

Are you pregnant Yes ___ No___ Do you anticipate becoming pregnant in the future Yes ___ No___

Are you nursing Yes ___ No ___

Medications

Are you taking, or have taken bone / metastatic disease medication: Fosamax _____ Boniva _____ Actonel ___

Didronel ____ Zometa (Intravenous/IV) ____ Aredia (IV) ___

Are you taking any Medications: Please Circle and **indicate name and dosage**:

Y N Antibiotics ______________________________	Y N Insulin ____________ Oral __________________
Y N Aspirin / Ibuprofen _______________________	Y N Blood Pressure ______________________________
Y N Antidepressants __________________________	Y N Heart Medications____________________________
Y N Tranquillizers ____________________________	Y N Blood Thinners ______________________________
Y N Birth Control _____________________________	Y N Nitroglycerin ________________________________
Y N Hormones ________________________________	Y N Marijuana etc. _______________________________
Y N Steroids _________________________________	Y N Other _____________________________________

Allergic / Allergies

Are you allergic or have experienced any unusual reaction to any drugs:

Y N Dental anesthetic	Y N Penicillin	Y N Erythromycin	Y N Aspirin / Ibuprofen
Y N Tetracycline	Y N Sulfa Drugs	Y N Codeine/ Narcotics	Y N Latex

Any other Drugs_____________________________ Any Allergies__________________________________

Do You Smoke Yes ____ No ____ Previous _____ How much per Day _______________________________

Do you Chew Tobacco Yes___ No___ Previous____ How much per Day______________________________

Do you drink alcohol Yes ___ No ___ How many drinks daily __________________________________

Patient Signature: ____ Date: _______________________