MEDICAL HISTORY

Physicians Name: ________________________________ Date of Last Visit: ________________

• Are you currently under medical treatment? ☐ Yes ☐ No

• Have you ever had any serious illnesses or operations? ☐ Yes ☐ No

Please describe if so: ____

Please list any and all current or past medical conditions:

____

• Are you currently taking any medication (including antibiotics)? ☐Yes ☐ No

Please describe if so: ____

• Do you smoke or use chewing tobacco? ☐ Yes ☐ No Are you pregnant? ☐ Yes ☐ No

• Do you have any dental implants? ☐ Yes ☐ No If so, where?_______________(top; bottom; right; left)

• Have you ever had any allergic reactions to the following:

☐ Local Anesthetics ☐ Penicillin ☐ Other Antibiotics ☐ Sulfa Drugs ☐ Aspirin ☐ Latex ☐ Iodine

☐ Nitrous Oxide ☐ Barbiturates (sleeping pills) ☐ Tetracycline ☐ Codeine ☐ Erythromycin ☐ Epinephrine

• Have you ever taken any of the following:

☐ Actonel ☐ Aredia ☐ Boniva ☐ Fosamax ☐ Reclast ☐ Zometa ☐ Herbal Supplements

☐ Bisphosphonate ☐ Recreational Drugs

Please check all that apply:

☐ Aids	☐ Chemical Dependency	☐ Headaches	☐ Kidney Disease	☐ Rheumatic Fever
☐ Anemia	☐ Chemotherapy	☐ Heart Murmur	☐ Liver Disease	☐ Scarlet Fever
☐ Arthritis	☐ Circulatory Problems	☐ Heart Problems	☐ Low Blood Pressure	☐ Shortness of Breath
☐ Artificial Heart Valves		☐ Hepatitis –type-	☐ Mitral Valve Prolapsed	☐ Sinus Trouble
☐ Artificial Joints	☐ Congenital Heart Disease	☐ Herpes	☐ Nervous Problems	☐ Stroke
☐ Asthma	☐ Cortisone Treatment	☐ High Blood Pressure	☐ Pins, Plates, Screws	☐ Swollen neck Gland
☐ Back Problems	☐ Diabetes	☐ HIV Positive	☐ Pacemaker	☐ Thyroid Problems
☐ Bleeding	☐ Epilepsy	☐ Hypoglycemic	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Disease	☐ Fainting or Dizziness	☐ Jaundice	☐ Radiation Treatment	☐ Tuberculosis
☐ Cancer	☐ Glaucoma	☐ Jaw Pain	☐ Respiratory Disease	☐ Ulcers
☐ Cardiovascular Disease				

Patient Signature: ________________________________ Date: ________________________

Doctor Signature: ________________________________ Date: ________________________