Medical History

Last Name:_____ First Name:_____ Birthdate:_____ M/F: ____

Name of Medical Doctor:_____ City/State:_____

Emergency Contact:_____ Phone:_____ Relationship: _____

Mark any medications that you are no longer taking and add any new ones:

☐ _____	☐ _____
☐ _____	☐ _____
☐ _____	☐ _____
☐ _____	☐ _____
☐ _____	☐ _____

Are you allergic to any of the following?

Y	N		Y	N		Y	N		Y	N	
☐	☐	Latex	☐	☐	Penicillin	☐	☐	Aspirin	☐	☐	Codeine
☐	☐	Metal	☐	☐	Local Anesthetics	☐	☐	Acrylic	☐	☐	Sulfa

Other:_____

Do you use controlled substances?:_____

Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?:_____

Do you take, or have you taken, Phen-Fen or Redux?:_____

Do you have any of the following medical conditions? (mark yes or no for all)

Y	N		Y	N		Y	N		Y	N	
☐	☐	AIDS/HIV Positive	☐	☐	Diabetes	☐	☐	Hepatitis B or C	☐	☐	Recent Weight Loss
☐	☐	Alzheimer's Disease	☐	☐	Drug Addiction	☐	☐	High Blood Pressure	☐	☐	Renal Dialysis
☐	☐	Anaphylaxis	☐	☐	Easily Winded	☐	☐	High Cholesterol	☐	☐	Rheumatic Fever
☐	☐	Anemia	☐	☐	Emphysema	☐	☐	Hives or Rash	☐	☐	Rheumatism
☐	☐	Angina/Chest Pains	☐	☐	Epilepsy or Seizures	☐	☐	Hypoglycemia	☐	☐	Scarlet Fever
☐	☐	Arthritis/Gout	☐	☐	Excessive Bleeding	☐	☐	Irregular Heartbeat	☐	☐	Shingles
☐	☐	Artificial Heart Valve	☐	☐	Excessive Thirst	☐	☐	Joint Replacement	☐	☐	Sickle Cell Disease
☐	☐	Asthma	☐	☐	Fainting Spells/Dizziness	☐	☐	Kidney Problems	☐	☐	Sinus Trouble
☐	☐	Blood Disease	☐	☐	Frequent Cough	☐	☐	Leukemia	☐	☐	Spina Bifida
☐	☐	Blood Transfusion	☐	☐	Frequent Headaches	☐	☐	Liver Disease	☐	☐	Stomach/Intestinal Disease
☐	☐	Breathing Problem	☐	☐	Glaucoma	☐	☐	Low Blood Pressure	☐	☐	Stroke
☐	☐	Bruise Easily	☐	☐	Hay Fever	☐	☐	Lung Disease	☐	☐	Swelling of Limbs
☐	☐	Cancer	☐	☐	Heart Attack/Failure	☐	☐	Mitral Valve Prolapse	☐	☐	Thyroid Disease
☐	☐	Chemotherapy	☐	☐	Heart Murmur	☐	☐	Osteoporosis	☐	☐	Tonsillitis
☐	☐	Cold Sores/Fever Blisters	☐	☐	Heart Pacemaker	☐	☐	Pain in Jaw Joints	☐	☐	Tuberculosis
☐	☐	Congenital Heart Disorder	☐	☐	Heart Trouble/Disease	☐	☐	Parathyroid Disease	☐	☐	Tumors or Growths
☐	☐	Convulsions	☐	☐	Hemophilia	☐	☐	Psychiatric Care	☐	☐	Ulcers
☐	☐	Cortisone Medicine	☐	☐	Hepatitis A	☐	☐	Radiation Treatments	☐	☐	Venereal Disease
									☐	☐	Yellow Jaundice

Other:_____

_____

Women, are you:

Pregnant?: Y ☐ N ☐ Trying to get pregnant?: Y ☐ N ☐ Nursing?: Y ☐ N ☐

Due Date:_____ Name of oral contraceptive, if applicable:_____

General:

Have you ever been hospitalized or had a major operation?:_____

Ever had a serious head or neck injury?:_____

Are you on a special diet?:_____

Tobacco use? If so, what kind and how much?:_____

Unusual reaction to dental injections?:_____

Reason for today's visit:_____ Are you in pain?:_____

Date: Signature:_____

(Patient or Parent/Guardian if patient is minor)