MEDICAL HISTORY

NAME _____

1. Have you been under the care of a medical doctor during the past two years?..... Yes No

   If yes, for what?_____

   Physician's Name_____ _____Phone_____

   Address_____City_____State_____Zip_____

2. Have you taken any medications or drugs during the last two years?..... Yes No
3. Are you taking any medications, drugs or pills now?..... Yes No

   Please list names and dosages. _____

   _____

4. Have you ever had an allergic or other type of reaction to any medication or substance?.... Yes No

   If yes, please list. _____

5. Have you been a patient in the hospital during the past five years?..... Yes No
6. Do you use more than two pillows to sleep?..... Yes No
7. Have you lost or gained more than ten pounds in the last year?.....Lost Gained No
8. Have you ever taken bisphosphonates? (Fosamax, Boniva, Aredia, Zometa)..... Yes No
9. **Women.** Are you: **Pregnant? ……**Yes, _____Months No **Nursing? ……** Yes No

   Taking Birth Control Pills? …… Yes No
10. Indicate which of the following you have had or have at present. Please circle "Yes" or "No" for each item

Heart Problems…….. Yes No

Heart Surgery …… Yes No

Chest Pain…….. Yes No

Congenital Heart Disease…… Yes No

Heart Murmur…… Yes No

High Blood Pressure…… Yes No

Mitral Valve Prolapse…….. Yes No

Artificial Heart Valve…… Yes No

Pacemaker……..……. Yes No

Defibrillator…… Yes No

Stents…… Yes No

Rheumatic Fever…….. Yes No

Stroke…….. Yes No

Swollen Ankles……..… Yes No

Arthritis/Rheumatism…….. Yes No

Cortisone Medication…….. Yes No

Artificial Joints (hip, knee, etc) Yes No

Osteoporosis…… Yes No

Diet (Special/Restricted)…… Yes No

Kidney Trouble…….. Yes No

Ulcers…… Yes No

Acid Reflux (GERD)…… Yes No

Diabetes…… Yes No

Hormone Replacement…… Yes No

Thyroid Problems……..… Yes No

Glaucoma…….. Yes No

Emphysema or COPD…….. Yes No

Tuberculosis…… Yes No

Asthma…… Yes No

Hay Fever…… Yes No

Allergies or Hives…… Yes No

Sinus Trouble……Yes No

Latex Sensitivity…… Yes No

Cancer or Tumors…… Yes No

Radiation Therapy…… Yes No

Chemotherapy……Yes No

Hepatitis A, B or C…… Yes No

Venereal Disease…… Yes No

AIDS/HIV…… Yes No

Cold Sores…… Yes No

Blood Transfusion…… Yes No

Hemophilia…… Yes No

Sickle Cell Disease…… Yes No

Bruise Easily……Yes No

Liver Disease…… Yes No

Yellow Jaundice…… Yes No

Neurological Disorders…… Yes No

Epilepsy or Seizures…… Yes No

Fainting or Dizzy Spells…… Yes No

Nervous/Anxious…… Yes No

Psychiatric/Psychological Care Yes No

Migraines…… Yes No

11. Do you have or have you had any other disease or condition not listed?…… Yes No

If yes, please list _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature_____Date_____