PATIENT NAME_______________________________________ **DATE**_______________

MEDICAL HISTORY

Your current physical health is ____Good ___Fair ___Poor

Do you have a personal physician? yes_____ No_______

Are you currently under the care of a physician? ________

Please explain_____________________________________

Do you smoke or use tobacco in any other form? _______

Are you in addiction recovery or in active addiction?_____

Have you had any pins, rods, or implants?_____________

Are you taking any prescription / over-the-counter drugs?

Please list each one:______________________________

____

For Women: Are you taking birth control pills?_______

Are you pregnant? ______Yes ______No

Are you nursing? ______Yes ______No

Have you ever had any of the following diseases or medical problems?

Y N Abnormal Bleeding
Y N Alcohol / Drug Abuse
Y N Anemia
Y N Arthritis
Y N Artificial bones/joints/valves
Y N Asthma
Y N Blood Transfusion
Y N Cancer / Chemotherapy
Y N Colitis
Y N Congenital Heart Disease
Y N Diabetes
Y N Difficulty Breathing
Y N Emphysema
Y N Epilepsy
Y N Fainting Spells
Y N Frequent Headaches
Y N Glaucoma
Y N Hay Fever
Y N Heart Attack
Y N Heart Murmur
Y N Heart Surgery
Y N Hemophilia
Y N Hepatitis A B C
Y N Herpes/Fever Blisters
Y N High Blood Pressure
Y N HIV+ / AIDS
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Mitral Valve Prolapse
Y N Pacemaker
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic Fever
Y N Scarlet Fever
Y N Seizures
Y N Shingles
Y N Sickle Cell Disease
Y N Sinus Problems
Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis (TB)
Y N Ulcers
Y N Venereal Disease

Have you ever been hospitalized for any reason?________

____

Are you allergic to any of the following?

Y N Aspirin Y N Erythromycin Y N Tetracycline
Y N Codeine Y N Latex Y N Other
Y N Dental Anesthetics Y N Penicillin

Please list any other drugs/materials that you are allergic to:

____

Have you been advised to take **pre-medication** before dental Treatment?

YES_________ **NO**_________

Are you taking medications for **osteoporosis?**

YES_________ **NO**_________

Name of medication _______________________________

Do you take **bisphosphonates** for any medical condition?

YES_________**NO**_________

Name of medication _______________________________

RECENT CHANGES IN MEDICAL HISTORY

Date	Change
________	____
________	____
________	____
________	____
________	____

RECENT CHANGES IN MEDICATION

________	____
________	____
________	____
________	____
________	____
________	____