MEDICAL HISTORY

- Are you under a physician's care now? Y ◻ N ◻ If yes, Whom: _____
- Have you ever been hospitalized or had a major operation? Y ◻ N ◻ *Explain*: _____

_____

- Have you ever had a serious head or neck injury? Y ◻ N ◻ *Explain*: _____

_____

- Are you taking any medications, pills, or drugs? Y ◻ N ◻ *Please List*: _____

_____

- Who prescribes your medications? _____
- Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? Y ◻ N ◻
- Are you on a special diet? Y ◻ N ◻ Do you use tobacco? Y ◻ N ◻ How much? _____

WOMEN: ◻ *Pregnant/trying to get pregnant* ◻ *Nursing* ◻ *Taking Oral Contraceptives/Other birth control*

Are you allergic to any of the following (please check all that apply):

◻ Aspirin ◻ Penicillin ◻ Codeine ◻ Acrylic ◻ Metal ◻ Latex ◻ Sulfa Drugs ◻ Local Anesthetics ◻ Other*_____

Do you use controlled substances? Y ◻ N ◻ Explain: _____

Do you have, or have you had any of the following (check all that apply):

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

Have you ever had any serious illness not listed? Y ◻ N ◻ Explain: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Printed Name: _____ Signature: _____ Date: _____