Medical History

Patient Name: _____ Nickname: _____ Age: _____

Primary Care Physician's Name: _____ Phone Number: _____

Are you currently under a doctor's care? _____ If yes, please describe _____
_____

Have you been hospitalized or had any surgeries in the last 5 years? _____ If yes, please describe _____
_____

Have you ever had an unfavorable reaction to dental treatment? _____ If yes, please describe _____
Do you smoke? _____ If yes, how long? _____ Packs per Day? _____ Do you use alcohol? _____If yes, how often? _____
Have you taken in the past 12 years, or are you currently taking, any bisphosphonate medications? ____ If yes, how long? _____
Which Medication? ☐ Actonel ☐ Fosamax ☐ Zometa ☐ Boneva ☐ Reclast ☐ XGeva ☐ Other: _____
WOMEN: Are you pregnant? _____ If yes, due date: _____ Are you nursing? _____ Are you taking birth control pills? _____

ALLERGIES (check all that apply)

☐ Aspirin
☐ Penicillin
☐ Erythromycin
☐ Sulfa Drugs
☐ Codeine
☐ Benzodiazepines
☐ Fluoride
☐ Dental Anesthetic
☐ Nitrous Oxide
☐ Latex
☐ Metals (gold, stainless steel)
☐ Other: _____
_____
_____
_____

MEDICAL CONDITIONS (check all that apply)

☐ Heart Problems
- ☐ Heart Attack
  When? _____
- ☐ Heart Defects
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Surgery
  When? _____
  Type: _____
- ☐ Other: _____

☐ Rheumatic Fever
☐ Scarlet Fever
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Chest Pain
☐ Pacemaker
☐ Stroke
☐ Artificial Pins, Bones, Joints
Type: _____
When? _____

☐ Artificial Heart Valve
When? _____
☐ Arthritis
☐ Blood Disorders
- ☐ Anemia
- ☐ Bruise Easily
- ☐ Hemophilia
- ☐ Prolonged Bleeding
- ☐ Sickle Cell Disease
- ☐ Other: _____

☐ Blood Thinners
☐ Respiratory Problems
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Persistent Cough
- ☐ Shortness of Breath
- ☐ Sinus Problems
- ☐ Other: _____

☐ Liver Disease

☐ Kidney Disease
☐ Tuberculosis
☐ Lupus
☐ Shingles
☐ Thyroid/Parathyroid Disease
☐ Diabetes
Type: _____
☐ Acid Reflux
☐ Stomach Ulcers
☐ Digestive Disorder
☐ Osteoporosis
☐ Glaucoma
☐ Alzheimer's or Dementia
☐ Contact Lenses
☐ Neurological Disorder
☐ Head or Neck Injuries
☐ Frequent Headaches
☐ Epilepsy or Seizures
☐ Fainting or Dizzy Spells
☐ Lumps or Swelling in Mouth

☐ Viral Infections/Cold Sores
☐ Tonsilitis
☐ TMJ Disorder
☐ Hives, Skin Rash, Hay Fever
☐ Sexually Transmitted Disease
☐ Hepatitis
Type: _____
☐ HIV/AIDS
☐ Hormone Deficiency
☐ Cancer
Type: _____
When? _____
☐ Radiation Therapy
When? _____
☐ Chemotherapy
When? _____
☐ Emotional Problems
☐ Psychiatric Disorders
☐ Antidepressant Medication
☐ Alcohol or Drug Dependency

Please list any serious medical conditions not indicated above that you have experienced in the last 5 years: _____
_____

Please list any **CURRENT** medications, supplements, or drugs you are taking: _____
_____
_____
_____

Please list any other medications, supplements, or drugs you have taken in the **PAST** 2 years: _____
_____
_____

PLEASE ADVISE US OF ANY CHANGES IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAKE BE TAKING.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set fourth above have been answered to my satisfaction. I will not hold my dentist or any member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Patient's Signature: _____ Date: _____