MEDICAL HISTORY

CIRCLE A DEFINITE ANSWER FOR EACH QUESTION:

Patient____ Date________________________

Name of Medical Physician ____M.D. Phone___________________________

Yes No Any change in your health in the last two years?

Yes No Are you currently under the care of a physician? If yes, describe your treatment_____________________________

____

Yes No Have you ever had any surgical operation of any kind? If yes, describe_____________________________________

____

Yes No Have you ever had a blood transfusion?

Yes No Have you been advised by a physician of the need for any type of surgery or treatment that you have not yet had?

If yes, for what?____

DO YOU HAVE, OR HAVE YOU BEEN TREATED FOR ANY OF THE FOLLOWING?:

Yes No AIDS/HIV

Yes No Allergies

Yes No Anorexia, Bulimia

Yes No Arthritis

Yes No Artificial Joints/Prosthetic Heart Valve

Yes No Asthma/Respiratory Problems

Yes No Blood Disorder

Yes No Cancer

Yes No Chemical Dependency

Yes No Chronic Sinus

Yes No Diabetes/Epilepsy

Yes No Dizziness/Fainting

Yes No Taken FenPhen/Redux

Yes No Fibromyalgia

Yes No Oral Herpes

Yes No Heart Disease

Yes No Heart Murmur

Yes No Mitral Valve Prolapse

Yes No Rheumatic Fever

Yes No Pacemaker- Type:______________

Yes No Hepatitis

Yes No High or Low Blood Pressure (if yes, circle one)

Yes No Kidney or Liver Disease (if yes, circle one)

Yes No Women: Are you pregnant?

Yes No Psychiatric Care

Yes No Radiation/Chemical Tx

Yes No Thyroid Condition

Yes No Tuberculosis

Yes No Ulcers

Yes No Growths/Tumors

Yes No Have you taken any bisphosphonate medications used to treat osteoporosis or any other bone loss related issues?

____

What is your typical blood pressure? S__________D___________ If unknown: High_____ Low_____ Normal_____

Yes No Has a Dr. ever advised you to take antibiotics prior to dental appointments? If yes, for what medical condition?

____

Yes No Have you ever had an allergic reaction (ie: medication, latex gloves) or been told not to take any medication? If yes, describe____

Yes No Are you currently taking any prescription or non-prescription drugs or medicines of any kind? If yes, what (example: Birth Control, Hormone, Diet, Aspirin, Cough Syrup)____

____

Yes No Have you had problems with prior dental treatment? (If yes, please explain)__________________________________

____

Yes No Do you have or have you had any other disease or medical problem NOT listed on this form? (If yes, please explain)____

____

Yes No Do you use any tobacco product? Daily intake____

Yes No Do you wear contact lenses?

Yes No Any type of jaw pain? (If yes, please complete attached jaw joint questionnaire)

I certify the above to be true and correct to the best of my knowledge.

Signature (Patient or guardian of Minor)____ Date______________

Dentist Signature____ Date___________________