



Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

Are you under medical treatment now? Yes No _____

Have you ever been hospitalized or had a major operation? Yes No _____

Have you ever had a serious head or neck injury? Yes No

Are you taking any medications, including non-prescription drugs? Yes No

If yes, please list the medications you are taking. _____

Do you or have you had a history of alcohol or drug abuse? Yes No

Do you use or have you used tobacco products? Yes No

Have you ever been treated for osteoporosis? Yes No

Have you ever taken Fosamax, Aresdia, Boniva, Zometa, Didronel, Skelid, Actonel or any other bisphosphonate medication? Yes No

Women Are you: Pregnant or think you may be pregnant? Yes No Due Date _____

Nursing? Yes No Taking oral contraceptives? Yes No

Do you have or have you had any of the following?

- | | | | | |
|--|--|--|--|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Alzheimer's disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Angina | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Parathyroid Disease |
| <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Steroid Treatment | <input type="checkbox"/> Radiation Treatments |
| <input type="checkbox"/> Pace Maker | <input type="checkbox"/> Cancer | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Herpes | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Asthma | <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Spina Bifida | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Stomach Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Other _____ |

Do you have any health problems that need further clarification? Yes No If yes, please explain

Are you allergic to or have you had adverse reaction to any of the following?

- Aspirin Penicillin or other antibiotics Codeine Acrylic Metal/Jewelry
 Latex/rubber Local anesthetics Other _____

IN CASE OF AN EMERGENCY THE PERSON TO CALL (Not Living with You)

Name _____ Phone _____

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.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN

DATE

OFFICE USE ONLY

Medical Update

Date	Medications/Changes/Comments	Staff
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Doctor/ Hygienist Notes: _____

