Medical History for:

first initial last

Date of Birth:

Date of last physical: Physician:

Are you under a physician's care?

If so why?

Have you ever had an operation?

If so, for what?

Do you have any artificial joints?	YES	NO
Do you have a heart murmur or artificial heart valve?	YES	NO
Have you ever had Rheumatic Fever of Rheumatic heart disease?	YES	NO
Women: Are you pregnant?	YES	NO

Do you have, or have you ever had any of the following:

A. Heart Attack	YES	NO
B. High or Low Blood Pressure	YES	NO
C. Stroke	YES	NO
D. Asthma	YES	NO
E. Hay Fever	YES	NO
F. Hives or skin rash	YES	NO
G. Fainting Spells	YES	NO
H. Seizures	YES	NO
I. Diabetes	YES	NO
J. Hepatitis	YES	NO
K. Jaundice or Liver Disease	YES	NO
L. Arthritis	YES	NO
M. Stomach Ulcers	YES	NO
N. Kidney Troubles	YES	NO
O. Epilepsy	YES	NO
P. Are you sensitive to metals or latex	YES	NO
Q. Do you have a pacemaker	YES	NO
R. Have you tested positive to HIV	YES	NO
S. Bled excessively after surgery or extractions	YES	NO
T. Anemia	YES	NO
U. Have you ever had a blood transfusion	YES	NO
V. Have you ever had radiation or chemo	YES	NO

Is there anything else we should know about your health that we have no covered on this form?

Are you now, or have you ever taken Fosamax, Actonel or Boniva for osteoporosis?	YES	NO
Have you ever taken the intravenous drugs Zometa, Bonefos or Aredia for multiple myeloma, Paget's Disease, or cancer of the breast, lung or other cancer?	YES	NO

Current Medications

1.	4.
2.	5.
3.	6.

Are you taking birth control pills?	YES	NO

Are you allergic to, or have you ever reacted adversely to, any of the following?

Penicillin	YES	NO
Sulfa	YES	NO
Other Antibiotic	YES	NO
Barbituates, sedatives or sleeping pills	YES	NO
Local Anesthetics	YES	NO
Aspirin	YES	NO
Ibuprofen	YES	NO
Any Other?	YES	NO

Dental History

If you are a new patient, date of last exam:		
Have you ever has orthodontic treatment (braces)	YES	NO
Have you had any serious trouble associated with previous dental treatment?	YES	NO
If so what?		
Been treated for gum disease (gingivitis, periodontitis, pyorrhea)	YES	NO
Do you grind or clench your teeth?	YES	NO
Do you smoke, chew, use snuff or any forms of tobacco?	YES	NO
Have you had a skin reaction to rubber products or latex?	YES	NO
Have you had any injuries to your mouth or jaws?	YES	NO
Have you been satisfied with your previous dental care?	YES	NO
If not, please explain		

Signature: **Date:**

Update:	Update:
Update:	Update: