PATIENT NAME: _________________________ DATE: _____________________

MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years? Yes No
   If Yes, for what? ____
   Physician's Name ______________________________ Phone # __________
2. Are you **currently** taking any medication or drugs, including regular doses of aspirin or over-the-counter herbal medicines? Yes No
   If yes, please list name and dosage ____
   ____
3. Have you taken any medication or drugs during the past two years that is not listed above? Yes No
   If Yes, please list name and dosage ___________________________________
   ____
   Have you ever taken prescription drugs for osteoporosis, including: Fosamax, Boniva, etc Yes No
   Have you ever taken any prescription drugs for weight loss, including Fen-Phen, Pondimen and Redux? Yes No
   If Yes to the above, did you have a medical exam for heart issues? Yes No
4. Are you aware of having an allergic (or adverse) reaction to any medication Yes No
   If Yes, please list ____
5. Have you been a patient in a hospital during the past five years? Yes No
   If Yes, for what reason? ____
6. Indicate which of the following you have had, or have at present**. Circle "Yes" or "No**"

Heart (Surgery, Disease, Attack)	Yes No	Ulcers …………………	Yes No	Hepatitis A B C ………	Yes No
Chest Pain ………………………	Yes No	Diabetes ……………	Yes No	Venereal Disease …..	Yes No
Congenital Heart Disease……….	Yes No	Thyroid Problems ..	Yes No	A.I.D.S. …………………..	Yes No
Heart Murmur ……………….	Yes No	Glaucoma …….	Yes No	H.I.V. Positive…………….	Yes No
High Blood Pressure ………………	Yes No	Contact Lenses . ..	Yes No	Cold Sores/Fever Blisters	Yes No
Mitral Valve Prolapse …………….	Yes No	Emphysema ……	Yes No	Blood Transfusion ……	Yes No
Artificial Heart Valve …………….	Yes No	Chronic Cough …..	Yes No	Hemophilia …………….	Yes No
Heart Pacemaker …………….	Yes No	Tuberculosis …….	Yes No	Sickle Cell Disease ……	Yes No
Rheumatic Fever …………….	Yes No	Asthma ………..	Yes No	Bruise Easily ……………	Yes No
Bacterial Endocarditis ………..	Yes No	Hay Fever ……..	Yes No	Liver Disease ………..	Yes No
Cortisone Medicine …………….	Yes No	Latex Sensitivity……	Yes No	Yellow Jaundice ……	Yes No
Swollen Ankles …………………..	Yes No	Allergies / Hives …….	Yes No	Neurological Disorder ..	Yes No
Stroke ……………………………………	Yes No	Sinus Trouble ……….	Yes No	Epilepsy or Seizures …..	Yes No
Diet (special/restricted) ………..	Yes No	Radiation Therapy ..	Yes No	Fainting/Dizzy Spells ……	Yes No
Artificial Joints (hip,Knee etc) .	Yes No	Chemotherapy …….	Yes No	Nervous/Anxious ………..	Yes No
When ___________________		Kidney Trouble …..	.Yes No	Tumors …………….	Yes No
Arthritis/Rheumatism	Yes No	Osteoporosis ……	Yes No	Osteonecrosis of Jaw ………..	Yes No
Psychiatric/Psychological Care	Yes No				

7. Have you lost or gained more than 10 pounds in the past year? ____________________________ Yes No
8. Do you sleep with more than 2 pillows? ____ Yes No
9. Do you have or have you had any disease, condition, or problem not listed? __________________ Yes No
   If yes, please list: ____
10. Women: Are you pregnant? ____ Yes No
11. Women: Do you use birth control medications? _______________________________________ Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of the knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the dentist of any changes in my health or medication.

Patient/Guardian Signature: ____ Date: __________________
History Review: ____
____

Doctor/Hygienist Signature: ____ Date: __________________