Medical History

Physician's Name ______________________________ Date of Last Visit ________

Are you taking any medications, vitamins or herbal supplements? _____ Yes _____ No

Please List:

a. ______________________________

b. ______________________________

c. ______________________________

Do you have any drug allergies or have an adverse reaction to any medication? ___ Yes __ No __ Don't Know

Please specify: ______________________________

				Reaction Type
Penicillin/Amoxicillin?	____ Yes	____ No	____ Don't Know	____________
Codeine?	____ Yes	____ No	____ Don't Know	____________
Anesthetics?	____ Yes	____ No	____ Don't Know	____________
Latex?	____ Yes	____ No	____ Don't Know	____________
Aspirin?	____ Yes	____ No	____ Don't Know	____________
Other?	____ Yes	____ No	____ Don't Know	____________

Have you ever responded adversely to medical or dental treatment? __ Yes ___ No ___ Don't Know

Have you ever bled excessively? ______________________________ __ Yes ___ No ___ Don't Know

Do you smoke or use any tobacco products? __ Yes ___ No ___ Don't Know

Do you drink alcohol? (If yes, please indicate how many drinks per week ____) __ Yes ___ No ___ Don't Know

Do you have anything artificial (pins, screws, valves, etc.) implanted in your body? __ Yes ___ No ___ Don't Know

Have you ever had a reaction to any type of metal? __ Yes ___ No ___ Don't Know

Have you ever been told that you need antibiotics before dental treatment? __ Yes ___ No ___ Don't Know

Have you had any type of surgery? Please List: ______________________________ __ Yes ___ No ___ Don't Know

____

Do you use a C-Pap machine at night for sleep apnea? __ Yes ___ No ___ Don't Know

Are you currently taking any medications for Osteoporosis or Osteopenia? __ Yes ___ No ___ Don't Know

(Actonel, Boniva, Didronel, Fosamax, Fosamax plus D, Skelid, Aredia, Bonefos, Zometa, Reclast, Forteo)

List date and length of time these medications were used: ______________ ______________

____

Do you have any other diagnosed conditions? __ Yes ___ No ___ Don't Know

(Developmental, Genetic, Psychiatric, Physical)

If so, explain ______________________________

Have you ever had head or neck radiation? __ Yes ___ No ___ Don't Know

Females: Do you suspect you may be pregnant? __ Yes ___ No ___ Don't Know

Are you nursing? __ Yes ___ No ___ Don't Know

Have you ever had any of the following conditions? Please circle all that apply.

Infective Endocarditis	Blood Disease	Internal Shunts	Kidney Disease	Asthma
Heart Transplant	Stomach Ulcers	Stroke	Venereal Disease	Tuberculosis
Heart Attack	Immune Disorders	Lung Disease	Tumors/Growths	Hemophilia
Congenital Heart Problems	Unusual Numbness	Liver Disease	Blood Transfusion	Epilepsy
Artificial Joints	AIDS/HIV	Chemical Dependency	Cancer	Fainting Spells/Seizures
Heart Disease/Conditions	Artifcial Heart Valves	Diabetes	Enlarged Heart	Hepatits A B C D
High/Low Blood Pressure				

Notes ______________________________

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Patient Signature ______________________________ Date ____________