MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____

Circle Appropriate Answer (leave blank if you do not understand question): Age: _____

Yes No Is your general health good?

Yes No Have you been hospitalized or had a serious illness in the last three years?

If yes, why? _____

Yes No Are you being treated by a physician now? For what? _____

Date of last medical exam? _____ Current Physician _____

HAVE YOU EXPERIENCED:

Yes No Chest pain (angina)
Yes No Shortness of breath
Yes No Fainting spells or Seizures
Yes No Bleeding problems, bruising easily

Yes No TMJ (jaw joint) problems
Yes No Sinus problems
Yes No Dry Mouth

DO YOU HAVE OR HAVE YOU HAD:

Yes No Heart Disease, Heart attack, heart defects
Yes No Heart murmurs or mitral prolapse
Yes No Rheumatic fever
Yes No Stroke
Yes No High Blood Pressure
Yes No Anemia
Yes No Stomach problems, ulcers
Yes No Asthma, TB, emphysema, other lung diseases
Yes No Immune Disorders
Yes No Tumors, cancer

Yes No Treatment with Steroids or Cortisone
Yes No Arthritis
Yes No Kidney, bladder disease
Yes No Thyroid, adrenal disease
Yes No Diabetes
Yes No Hepatitis, other liver disease
Yes No Allergy to Medications
_____
_____

DO YOU HAVE OR HAVE YOU HAD:

Yes No Radiation treatments
Yes No Chemotherapy/IV Bisphosphonate, treatment for bones
Yes No Prosthetic heart valve
Yes No Artificial joint

Yes No Allergy to Penicillin
Yes No Allergy to Latex
Yes No Blood transfusions
Yes No Pacemaker
Yes No Contact lenses
Yes No Head or Neck/Oral Cancer

ARE YOU TAKING:

Yes No Recreational drugs
Yes No Prescription Drugs or over-the-counter medicines
Yes No Aspirin

Yes No Tobacco in any form? Amount? _____
Yes No Alcohol? Amount? _____
Yes No Herbal Supplements?

Yes No Are you taking **or have you ever taken** Bisphosphonates for osteoporosis, multiple myeloma or other cancers. (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa, Prolia ?)

PLEASE LIST CURRENT MEDICATIONS _____

_____

_____

WOMEN ONLY:

Yes No Are you or could you be Pregnant or Nursing?
Yes No Taking Birth Control Pills?

ALL PATIENTS:

Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form? If so please explain:

_____

Please list all past SURGICAL PROCEDURES _____

Prior HOSPITALIZATIONS: _____

Height _____ Weight _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient _____ Staff _____ Date _____

BP _____ Pulse _____ Soft Tissue Exam

Findings