

MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years?..... Yes No
If yes: for what reason? _____
Please provide the name, address, and telephone number of your physician.

2. Have you been a patient in the hospital during the past five years?..... Yes No
If yes: for what reason? _____

3. Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin?
 Yes No If yes, please list: _____

4. Have you taken any medicine or drugs during the past two years? If yes, please list: Yes No

5. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? Yes No
If yes, did you take any of the following: (circle if yes) Fen-Phen Pondimen Redux Other
If yes to any of the above, did you have a medical exam for heart issues? Yes No

6. Are you aware of having an allergic (or adverse) reaction to any substance or medication?..... Yes No

7. Are you on a special diet?..... Yes No

8. Check any of the following, which apply in either past or present:

- | | | |
|--|--|---|
| <input type="checkbox"/> Heart (Surgery, Disease, Attack) | <input type="checkbox"/> Latex Sensitivity | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Hepatitis A B C (circle) |
| <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Diabetes | <input type="checkbox"/> A.I.D.S./H.I.V. Positive |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Cold Sores / Fever Blisters |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> Artificial Heart Valve / Pacemaker | <input type="checkbox"/> Contact Lenses | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Artificial Joints (hip, knee, etc.) | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Bruise Easily |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Liver Disease / Yellow Jaundice |
| <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Asthma | <input type="checkbox"/> Neurological Disorders |
| <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Hay Fever / Allergies / Hives | <input type="checkbox"/> Epilepsy or Seizures |
| <input type="checkbox"/> Swollen Ankles | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Fainting or Dizzy Spells |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Nervous / Anxious |
| <input type="checkbox"/> Diet (Special / Restricted) | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Psychiatric / Psychological Care |

9. Do you have any disease, condition or problem not listed? If so, please list..... Yes No

10. **Women:** Are you pregnant or think you could be pregnant? Yes _____ Months No **Nursing?** Yes No

11. Do you use birth control prescriptions?..... 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 my 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 doctor of any change in my health or medication.

Patient / Guardian Signature _____ Date _____