MEDICAL HISTORY INFORMATION

Name of Physician: ____ Phone: (___)____________________________

Do you have or have you ever had any of the following? Please check only the ones that apply:

☐ Acid Reflux	☐ Chemotherapy	☐ Heart Surgery*	☐ Radiation Treatment
☐ Allergies/Hay Fever	☐ Depression	☐ Hepatitis B or C	☐ Respiratory Issues
☐ Anemia	☐ Diabetes	☐ High Blood Pressure	☐ Rheumatic Fever
☐ Angina	☐ Epilepsy	☐ HIV/AIDS*	☐ Rheumatism
☐ Anxiety	☐ Excessive Thirst	☐ Kidney Problems	☐ Sickle Cell Disease
☐ Arthritis	☐ Fainting or Dizziness	☐ Liver Problems	☐ Sinus Problems
☐ Artificial Joint*	☐ Fever Blisters/Cold Sores	☐ Low Blood Pressure	☐ Stomach Ulcers
☐ Artificial Heart Valves*	☐ Frequent Cough	☐ Lupus	☐ Stroke
☐ Asthma	☐ Glaucoma	☐ Mental Disorders	☐ Surgical Stint
☐ Blood Thinner Use	☐ Heart Disorder*	☐ Migraines	☐ Thyroid Problems
☐ Breathing Problems	☐ Heart Infection*	☐ Mitral Valve Prolaps	☐ Tuberculosis
☐ Cancer	☐ Heart Murmur*	☐ Osteoporosis	☐ Venereal Disease
☐ Chemical Dependency	☐ Heart Pace Maker	☐ Panic Attacks	☐ Organ Transplant **Surgery**

***This condition may require antibiotic pre-medication for certain dental procedures**

Are you now under the care of a physician? If yes, explain:____

Do you have any health problems that were not listed above? If yes, explain ______________________________

Are you taking any medications or herbals currently? If yes, please list: _________________________________

Are you allergic to any medications or substances: ☐ Aspirin ☐ Codeine ☐ Iodine ☐ Latex

☐ Local injected Anesthetics ☐ Metal of any Kind ☐ Penicillin ☐ Other________________________

Do you use any of the following or any type of osteoporosis medication: ☐ Fosamax ☐ Boniva

☐ Didronel ☐ Acotnel ☐ Acotnel with Calcium ☐ Reclast

Have you or do you use any type of tobacco? If yes, please explain what type_____________________________

(women) Are you pregnant:________ How far along?____

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I will inform the dentist and the staff at the next appointment without fail.

X____ **Today's Date** ___________________________

Signature of patient, parent or guardian