MEDICAL HISTORY FORM (Page 1)

PATIENT NAME _____ BIRTH DAY _____/_____/_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Please be as thorough as possible. Thank you.

Are you currently under the care of a Physician? ___YES ___NO If yes explain _____

Physician's Name _____

Are you under the care of a Specialist? ___YES ___NO If yes explain _____

Specialist's Name _____

Have you been Hospitalized in the last 5 years? ___YES ___NO If yes explain _____

_____

Are you taking any Medications or Supplements? ___YES ___NO If yes please give the name and dosing of each _____

_____

Are you taking Blood Thinners? ___YES ___NO If yes explain_____

Have you ever taken Fosamax, Boniva, Actonel

or any other Bisphosphonate? ___YES ___NO If yes explain _____

Do you have a history of Tobacco use? ___YES ___NO If yes explain _____

Are you interested in stopping? ___VERY ___SOMEWHAT ___ NOT INTERESTED

Do you use controlled substances? ___YES ___NO If yes explain _____

Do you drink Alcoholic Beverages? ___YES ___NO Drinks in a day? _____ or Drinks in a week? _____

Do you need Antibiotics prior to a dental appt? ___YES ___NO If yes explain _____

Have you ever had a Joint Replacement? ___YES ___NO If yes explain_____

Any history of previous Endocarditis? ___YES ___NO If yes explain_____

Any history of Chemotherapy or Radiation? ___YES ___NO If yes explain_____

Women: Are you Pregnant? ___YES ___NO Nursing? ___YES ___NO Taking Oral Contraceptives? ___YES ___NO

Are you **ALLERGIC** to any of the following:

Aspirin? ___YES ___NO Penicillin? ___YES ___NO Codeine or other Narcotics? ___YES ___NO

Latex? ___YES ___NO Metal? ___YES ___NO Sulfa Drugs? ___YES ___NO

Local Anesthetics? ___YES ___NO Acrylic? ___YES ___NO Topical Anesthetics? ___YES ___NO

Other? ___YES ___NO If yes explain _____

To the best of my knowledge, the questions on this form have been answered accurately. It is my responsibility to inform the dental office of any changes in my medical status.

Patient Signature _____ DATE _____/_____/_____

Guardian Signature (if under 18) _____ Relationship _____