PATIENT'S NAME _____ ☐ M ☐ F

Does your medical history include any of the following:

Y	N	CONDITIONS
☐	☐	Abnormal breathing
☐	☐	Alcohol abuse
☐	☐	Allergies
☐	☐	Allergies to medication
☐	☐	Anemia
☐	☐	Angina or chest pain
☐	☐	Are you in general good health?
☐	☐	Arrhythmia
☐	☐	Arthritis
☐	☐	Artificial heart valve
☐	☐	Artificial joint(s)
☐	☐	Asthma
☐	☐	Cancer - Chemotherapy
☐	☐	Colitis
☐	☐	Congenital heart defect
☐	☐	Currently taking medication
☐	☐	Diabetes
☐	☐	Drug abuse / Street drugs
☐	☐	Fever blisters
☐	☐	Glaucoma
☐	☐	HIV+ AIDS
☐	☐	Heart attack
☐	☐	Heart murmur
☐	☐	Heart surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A, B, C
☐	☐	High blood pressure
☐	☐	Kidney problems
☐	☐	Liver disease
☐	☐	Major operation

Y	N	CONDITIONS
☐	☐	Mitral valve prolapse
☐	☐	Pacemaker
☐	☐	Rheumatic Fever / Scarlet Fever
☐	☐	Seizures
☐	☐	Sickle Cell disease
☐	☐	Stroke
☐	☐	Thyroid problems
☐	☐	Tuberculosis
☐	☐	Tumors or growths
☐	☐	Venereal disease
☐	☐	Yellow Jaundice
☐	☐	Low bone density / Osteoporosis

Y	N	ALLERGIES
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythomycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

_____

_____

_____

Y	N	MEDICATIONS
☐	☐	Bisphosphonate medication
☐	☐	Taken Aredia or Zometa
☐	☐	Taken Fosamax or Actonel
☐	☐	Boniva or Ibandronate Sodium
☐	☐	Pamisol or Alendronate
☐	☐	Risedronate or Pamidronate
☐	☐	Zoledronate or Etidronate
☐	☐	Clodronate or Tiludronate
☐	☐	Reclast
☐	☐	Coumadin
☐	☐	Plavix
☐	☐	Warfarin
☐	☐	Garlic or Ginger
☐	☐	Ginko or Ginseng
☐	☐	Vitamin E
☐	☐	Fish Oil or Fever Few
☐	☐	Kava or Valerium
☐	☐	St. John's Wart

IF FEMALE,
PLEASE ANSWER THE FOLLOWING:

Y	N	
☐	☐	Are you taking birth control pills?
☐	☐	Are you pregnant? If Yes, number of weeks: _____
☐	☐	Are you nursing?

FOR OFFICE USE ONLY

HEART RATE _____

BLOOD PRESSURE _____ / _____

PLEASE LIST ANY OTHER DISEASES, CONDITIONS OR PROBLEMS WE SHOULD KNOW ABOUT:

_____

_____

PLEASE LIST ANY OVER THE COUNTER OR PRESCRIPTION MEDICATIONS OR SUPPLEMENTS YOU ARE TAKING:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PHYSICIAN'S NAME _____ PHONE _____

SPECIALTY PHYSICIAN'S NAME _____ PHONE _____

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 SIGNATURE (PARENT SIGNATURE IF MINOR) X _____ DATE _____