MEDICAL HISTORY FORM

Patient Name_____ **Birthdate**_____ **Date**_____

Please circle appropriate answer (ok to leave blank if you don't understand the question)

Yes No Is your general health good?
Yes No Has there been a change in your health in the last year?

Yes No Are you under the care of a physician? If Yes, name & phone_____
If Yes, what is the condition being treated?_____ Date of last medical exam_____
Yes No Have you been hospitalized or had a serious illness in the last five (5) years?
If Yes, please explain_____

Yes No Have you had problems with prior dental treatment? _____
Date of last dental exam_____
Yes No Are you in pain now? Describe _____

Are you taking, or have you ever taken bone/metastatic disease medication (bisphosphonates)? Yes / No For how long?_____

_____ Zometa (Intravenous/IV)	_____ Boniva	_____ Actonel
_____ Aredia (Intravenous/IV)	_____ Didronel	_____ Fosamax
_____ Reclast (injection 1x/year)		

Have you ever had, or currently have, the following: (circle Yes/No)

Y N Cancer or Tumors	**Y N** Diabetes (Type___)	**Y N** Psychiatric Care
Y N Radiation Therapy	**Y N** Bleeding/Bruising Problems	**Y N** Depression
Y N Chemotherapy(injections/pills)	**Y N** Adrenal Disease	**Y N** Seizures
Y N Heart Attack, Heart Defects	**Y N** Thyroid Disease	**Y N** STD (Syphilis, Herpes or Gonorrhea)
Y N Heart Trouble	**Y N** Stroke	**Y N** HIV/AIDS
Y N Pacemaker	**Y N** Osteoporosis	**Y N** Liver Disease/Hepatitis (Type__)
Y N Prosthetic Heart Valve	**Y N** Kidney Disease	**Y N** Blood Transfusion
Y N Infective Endocarditis	**Y N** Artificial Joint	**Y N** Auto Immune Disorders
Y N Low Blood Pressure	**Y N** Arthritis	**Y N** Asthma
Y N High Blood Pressure	**Y N** Allergies/Sinus	**Y N** Tuberculosis, Emphysema or Other Lung
Y N Frequent Headaches	**Y N** Stomach Ulcer	Disease

Yes No Allergies to drugs food or latex? Please list_____

Yes No Are you taking any prescribed or over-the-counter medications? (Include aspirin, vitamins & natural remedies) Please list:
_____
_____

Any disease, problem, or prolonged illness not listed on this form? Yes No Please explain:_____

Have you ever used:
Yes No Tobacco? (cigarettes, cigars, pipes, chewing tobacco)
How much per day? _____ For how long?_____ Quit date_____
Yes No Recreational drugs?_____
Do you currently use: Alcohol? **Yes No** Daily? **Yes No**

Women Only
Yes No Do you use birth control pills? Please list_____
Yes No Are you, or could you be pregnant? If Yes, due date?_____
Yes No Are you nursing?

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 medications.

Patient Signature_____Date_____

Dentist Signature_____Date_____Hygienist Initials_____

Reviewed/Updated: _____ Date: _____ | _____ Date:_____
Signature *Signature* *modified 3/27/11*