Medical History

Patient Name _____ Patient Birthday_____

If you are completing this for another person, what is your relationship to that person? _____

YES NO ……	Are you under the care of a physician? Name of Physician_____ Phone _____ Address of physician_____
YES NO ……	Are you in good health?
YES NO ……	Has there been any change in your health in the past year? If yes, what condition has changed?
_____	Date of last physical exam?
YES NO ……	Have you had any serious illness or operation or been hospitalized in the last 5 years? If yes, please explain:

Allergies

	Are you **allergic** to or have you had a reaction to: (For all yes responses, please specify type of reaction)
YES NO ……	Local Anesthetics _____
YES NO ……	Penicillin_____
YES NO ……	Sulfa Drugs_____
YES NO ……	Other Antibiotics_____
YES NO ……	Codeine_____
YES NO ……	Hydrocodone (Vicodin or Norco) _____
YES NO ……	Other Narcotics_____
YES NO ……	Benzodiazipines (Valium, Ativan) _____
YES NO ……	Aspirin_____
YES NO ……	Tylenol_____
YES NO ……	Latex_____
YES NO ……	Metals_____
YES NO ……	Other_____

Have you ever had any of the following conditions? Where YES, please explain where necessary.

YES NO …….	Artificial heart valve
YES NO ……	Previous infective endocarditis
YES NO ……	Congenital heart disease (CHD). If yes, please circle or explain. Unrepaired, cyanotic Repaired completely in last 6 months Repaired with residual defects

YES NO	Joint Replacement. Have you ever had an orthopedic total joint (hip, knee, elbow, etc) replacement? If yes, which joint and when? _____ Did you have any complications?

YES	NO	.....	Cardiovascular disease	YES NO	Osteoporosis
YES	NO	.....	Congestive heart failure	YES NO	Arthritis
YES	NO	.....	Atrial fibrillation	YES NO	Acid reflux/heartburn
YES	NO	.....	Heart attack	YES NO	Ulcers
YES	NO	.....	Heart murmur	YES NO	Frequent vomiting or history
YES	NO	.....	Mitral Valve Prolapse	YES NO	Frequent canker sores
YES	NO	.....	High blood pressure	YES NO	Cold sores/herpes
YES	NO	.....	Thyroid problem	YES NO	Asthma
YES	NO	.....	Low blood pressure	YES NO	Emphysema/COPD
YES	NO	.....	Pacemaker. If yes, when?	YES NO	Sinus trouble
YES	NO	.....	Anemia	YES NO	Stroke
YES	NO	.....	Abnormal bleeding/hemophilia	YES NO	Epilepsy
YES	NO	.....	Liver disease	YES NO	Fainting Spells
YES	NO	.....	Hepatitis A B C	YES NO	Severe headaches/migraines
YES	NO	.....	Kidney disease	YES NO	Vertigo
YES	NO	.....	Diabetes type I or II	YES NO	Alzheimer's or dementia
YES	NO	.....	Recurrent infections	YES NO	Substance abuse (or history of)
YES	NO	.....	HIV/AIDS	YES NO	Recreational drugs
YES	NO	.....	Tuberculosis	YES NO	Mental health disorder(s)
YES	NO	.....	Autoimmune disease	YES NO	Depression
YES	NO	.....	Lupus	YES NO	Anxiety

YES NO	Have you ever been diagnosed with cancer? If yes, what type?
YES NO	Have you been in chemotherapy during the last 12 months?
YES NO	Have you been in radiation therapy in the last 12 months?
YES NO	Have you ever been diagnosed with head or neck cancer?
YES NO	Have you ever received radiation therapy to your head or neck?

YES NO	FOR WOMEN ONLY: Are you pregnant? Number of weeks:

YES NO	FOR WOMEN ONLY: Are you nursing?

Specific Medication Questions

YES NO	Have you ever taken medications such as alendronate (Fosamax) or risedronate (Actonel) for osteoporosis or Paget's disease?
YES NO	Have you ever been treated or are you scheduled to start treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia, skeletal complications from Paget's disease, multiple myeloma or metastatic cancer? If yes, please note year of treatments.
YES NO	Do you take blood thinners? If yes, circle or write in the medication Coumadin/Warfarin Plavix/Aggrenox Baby Aspirin Other_____
YES NO	Has a physician or dentist recommended that you take antibiotics prior to your dental treatment? If yes, who made the recommendation and for what condition? _____

YES NO …….	Do you currently use tobacco? If yes, describe.
YES NO ……	Have you used tobacco regularly in the past?
YES NO ……	Do you drink alcohol? How many drinks per week?

Please list all current medications:

1. Medication: Condition:
2. Medication: Condition:
3. Medication: Condition:
4. Medication: Condition:
5. Medication: Condition:
6. Medication: Condition:

Do you have any disease, condition or problem that you think we should know about? Please explain:

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Guardian_____Date_____