Medical History

Patient Name__________________Date:________________

Address: ______________________________ Phone: __________________Date of Birth:_______________

Are you under a physician's care? ________ Name of physician: _____________________________________

Are you taking any medications? ________ If yes, please list: _____________________________________

Have you ever taken Fosamax, Boniva, Actonel or any other medications for osteoporosis?________

If yes, for how long: _____________________________

Do you take blood thinners? __________

Do you use controlled substances? _______

Do you use tobacco? _______

Have you been instructed by your physician to take antibiotics before dental treatment? _______

Are you pregnant? ____________ Due date: ____________

Have you ever had any complications following dental treatment? ____________________________________

Have you ever had any of the following?

Abnormal Blood Pressure	Yes	No	Glaucoma	Yes	No
Abnormal Heart Condition	Yes	No	Heart Murmur	Yes	No
AIDS/HIV Positive	Yes	No	Hepatitis	Yes	No
Anemia	Yes	No	Kidney Problems	Yes	No
Artificial Joint	Yes	No	Mitral Valve Prolapse	Yes	No
Asthma	Yes	No	Osteoporosis	Yes	No
Blood Transfusion	Yes	No	Pacemaker	Yes	No
Cancer	Yes	No	Radiation Treatments	Yes	No
Chemotherapy	Yes	No	Rheumatic Fever	Yes	No
Cold Sores/Fever Blisters	Yes	No	Sinus Problems	Yes	No
Diabetes	Yes	No	Stroke	Yes	No
Drug/Alcohol Addiction	Yes	No	Stomach Problems	Yes	No
Excessive Bleeding	Yes	No	Thyroid Problems	Yes	No
Fainting	Yes	No	Tuberculosis	Yes	No

Is there any other additional information about your health we should know?

____

Are you allergic to? *Penicillin* *Codeine* *Sulfa* *Latex*

Do you have any other allergies? ____

To the best of my knowledge, I have answered every question completely and accurately. I understand that providing information that is incorrect or false could be dangerous to my or the patient's health. I understand that I am responsible for informing Dentists, Inc. of any changes in my medical history.

Signature of Patient, Parent, or Guardian Date