MEDICAL AND PERSONAL HISTORY
PLEASE PRINT

Patient's Name: Miss, Mrs., Ms., Mr., Dr.: _____
Birthdate: _____ Sex: _____ Parent's Name (If Minor) _____
Who Referred You To This Office: _____
Your General Dentist's Name: _____
Your Physician's Name: _____
Is Your Present Health: (circle one) Good Fair Poor
Who Can We Contact In Case Of Emergency: _____ Phone: _____
Are You Having Any Pain Or Discomfort At This Time?: _____

CHECK ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT PRESENT

____ Heart Condition	____ Lung Disease	____ Cancer or Tumor
____ Heart Murmur	____ Asthma or Hay Fever	____ Radiation/Chemotherapy
____ Artificial Heart Valve	____ Kidney Trouble	____ Venereal Disease
____ High Blood Pressure	____ Diabetes	____ Epilepsy or Seizures
____ Rheumatic Fever	____ Thyroid Disease	____ Artificial Joint
____ Blood Transfusion	____ Hepatitis or Liver Disease	____ HIV Infection

1. Have you ever taken any drugs for osteoporosis or other bone disorders? ..... Yes No
2. Have you ever taken bisphosphonate meds, such as Actonel or Fosamax? ..... Yes No
3. Are you allergic to any medicines, drug, Latex or any other substance? ..... Yes No
   If yes, please list _____
4. Do you smoke or use smokeless tobacco? ..... Yes No
5. Have you ever taken the diet drug PHEN-FEN/REDUX ..... Yes No
6. List any diseases, conditions or problems not shown above. _____
   _____
7. List any medicine or drugs you are presently taking. _____
   _____
8. Have you ever been hospitalized or had surgery? ..... Yes No
9. Have your ever had a reaction to a local anesthetic? ..... Yes No
10. Have you ever had prolonged or unusual bleeding? ..... Yes No
11. Have you ever had complications or illness following dental treatment? ..... Yes No
12. Have you ever had an injury or trauma to your face or jaw? ..... Yes No
13. Are you nervous or concerned about having dental work done? ..... Yes No

Women: Are you pregnant now? Due Date ..... Yes No
Are you practicing birth control? ..... Yes No
Do you anticipate becoming pregnant? ..... Yes No

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medications change, I will inform the doctor at the next appointment without fail.

_____ _____
Date Signature of patient or parent if minor