

**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

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Heart Condition        | <input type="checkbox"/> Lung Disease               | <input type="checkbox"/> Cancer or Tumor        |
| <input type="checkbox"/> Heart Murmur           | <input type="checkbox"/> Asthma or Hay Fever        | <input type="checkbox"/> Radiation/Chemotherapy |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Kidney Trouble             | <input type="checkbox"/> Venereal Disease       |
| <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Epilepsy or Seizures   |
| <input type="checkbox"/> Rheumatic Fever        | <input type="checkbox"/> Thyroid Disease            | <input type="checkbox"/> Artificial Joint       |
| <input type="checkbox"/> Blood Transfusion      | <input type="checkbox"/> Hepatitis or Liver Disease | <input type="checkbox"/> 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