Medical History:

Do you have a personal physician? ( ) YES ( ) NO

If yes, Physician's name: _____

Contact #'s: (Phone) _____ (Fax) _____

Date of last visit: _____

Are you currently under continuing care of a physician, outside of routine physicals, exams, etc?

( ) YES ( ) NO

If YES, please explain: _____

_____

How often are you seen for this/these concern(s)? _____

Are you currently taking any prescription or over the counter drugs, vitamins, supplements, etc?

( ) YES ( ) NO

Please list each one and indicate whether you take it daily or as needed:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Have you ever taken Fosamax or any other bisphosphonate? ( ) YES ( ) NO

Have you ever taken Phen-Fen? ( ) YES ( ) NO

Women: Are you pregnant? ( ) YES; Week # _____ ( ) NO

Are you nursing? ( ) YES ( ) NO

Are you using a prescribed method of birth control? ( ) YES Name: _____

( ) NO

Medical History Continued…….

Are you allergic to any of the following?

Aspirin	**( ) Yes ( ) No**	**Dental Anesthetics**	**( ) Yes ( ) No**	**Jewelry**	**( ) Yes ( )No**
Codeine	**( ) Yes ( ) No**	**Latex**	**( ) Yes ( ) No**	**Erythromycin**	**( ) Yes ( )No**
Penicillin	**( ) Yes ( ) No**	**Metals/Plastics**	**( ) Yes ( ) No**	**Tetracycline**	**( ) Yes ( ) No**
Ibuprofen	**( ) Yes ( ) No**				

Please list any other drugs, foods, or materials that you are allergic to or have an adverse reaction from?

_____

_____

Please list any serious medical condition(s)that you have ever had: _____

_____

Have you ever had any of the following diseases or medical concerns?

Abnormal Bleeding	**( ) Yes ( ) No**	**Hemophilia**	**( ) Yes ( ) No**
Anemia	**( ) Yes ( ) No**	**Hepatitis**	**( ) Yes ( ) No**
Arthritis	**( ) Yes( ) No**	**HIV/AIDS**	**( ) Yes( ) No**
Blood Transfusion	**( ) Yes ( ) No**	**Kidney Problems**	**( ) Yes ( ) No**
Congenital Heart Defect	**( ) Yes ( ) No**	**Mitral Valve Prolapse**	**( ) Yes ( ) No**
Difficulty Breathing	**( ) Yes ( ) No**	**Psychiatric Problems**	**( ) Yes ( ) No**
Drug/Alcohol Abuse	**( ) Yes ( ) No**	**Rheumatic/Scarlet Fever**	**( ) Yes ( ) No**
Emphysema	**( ) Yes ( ) No**	**Shingles**	**( ) Yes ( ) No**
Fainting/Dizziness	**( ) Yes ( ) No**	**Sickle Cell Disease/Traits**	**( ) Yes ( ) No**
Glaucoma	**( ) Yes ( ) No**	**Sinus Problems**	**( ) Yes ( ) No**
Hay Fever	**( ) Yes ( ) No**	**Tuberculosis (TB)**	**( ) Yes ( ) No**
Heart Murmur	**( ) Yes ( ) No**	**Ulcers/Colitis**	**( ) Yes ( ) No**

Have you ever had any of the following diseases or medical problems?

Artificial Bones/Joints/Valves: ( ) Yes ( ) No

If yes, what type and when was it placed? _____

_____

***Do you require premedication prior to dental treatment? ( ) Yes ( ) No**

Asthma: ( ) Yes ( ) No ( ) As a child/outgrew it ( ) Exercise Induced ( ) Allergy Induced

If yes, is it currently controlled? ( ) Yes How? _____

( ) No

Do you require a rescue inhaler? ( ) yes ( ) No

Cancer: ( ) Yes ( ) No

If yes, what type of cancer? _____

Which types of treatment did you receive? ( ) Chemotherapy ( ) Radiation

Length of treatment time? _____

Cold sores? ( ) Yes ( ) No

If yes, frequency of outbreak? _____

Diabetes? ( ) Yes ( ) No

If yes, what medications do you take? _____

_____

Heart Disease/Heart Attack/Stroke? ( ) Yes ( ) No

If yes, which illness have you experienced? _____

Date of incident(s): _____

Additional Information, concerns, etc: _____

High ( ) or Low ( ) Blood pressure? ( ) Neither

Do you require medication to manage this condition? ( ) Yes ( ) No

Medical Information Continued…….

Have you ever had any of the following diseases or medical concerns?

Respiratory Problems/Trouble Breathing? ( ) Yes ( ) No

If yes, please explain: _____

Do you require Oxygen? ( ) Yes ( ) No

Sleep Apnea/Sleeping Disorders/Snoring? ( ) Yes ( ) No

If yes, please explain: _____

Thyroid Conditions? ( ) Yes: ( ) Underactive ( ) Overactive

( ) No

If yes, Name of medications taken: _____

Any other medical concerns or conditions not listed above? _____

_____

_____

_____

Do you smoke or use smokeless tobacco? ( ) Yes: How often? _____

( ) No

( ) I Quit How long? _____

Have you ever experienced acid reflux? ( ) Yes How often? _____

( ) No

( ) Previously

Do you experience headaches/migraines? ( ) Yes: How often: _____

( ) No