Patient Name:_____ Date of Birth:_____/_____/_____

Physician:_____ Address:_____ Phone:_____

Are you current under a physician's care? No Yes If Yes, for what?_____

Answer 'YES' if you have or had any of the following conditions. Answer 'NO' if you have never had the following.

Heart Attack	☐ Yes ☐ No	Asthma	☐ Yes ☐ No	Hepatitis A (Infectious)	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Hepatitis B (Serum)	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Drug Allergies	☐ Yes ☐ No	Hepatitis C	☐ Yes ☐ No
Low Blood Pressure	☐ Yes ☐ No	Latex Allergy	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No	HIV Positive	☐ Yes ☐ No
Heart Valve Repair	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Congenital Heart Disease	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Cold Sores	☐ Yes ☐ No
Heart Surgery	☐ Yes ☐ No	Cancer	☐ Yes ☐ No	Drug/Alcohol Abuse	☐ Yes ☐ No
Infective Endocarditis	☐ Yes ☐ No	Radiation Therapy	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No
Mitral Valve Prolapse	☐ Yes ☐ No	Chemotherapy	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No
Artificial Joint	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Fainting Spells	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Anemia	☐ Yes ☐ No	Steroid Medication	☐ Yes ☐ No
Tuberculosis	☐ Yes ☐ No	Blood Thinners	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No

Describe any past/present medical condition not listed above:_____

_____

List all current medications:_____

_____

List any drugs you are allergic to:_____

_____

Have you required antibiotics before dental treatments? ☐ Yes ☐ No If Yes, why?_____

Women: Are you pregnant? ☐ Yes ☐ No How many months?_____ Taking oral birth control pills? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No Type:_____ Amount:_____ How long?_____

Have you ever taken: Fosamax, Actonel, Boniva, Didronel, Skelid, Aredia, Bonefos, Reclast or Zometa? ☐ Yes ☐ No

PATIENT SIGNATURE (OR LEGAL GUARDIAN):_____DATE:_____

I have reviewed and updated this form. Signature_____ Date:_____/_____/_____

I have reviewed and updated this form. Signature_____ Date:_____/_____/_____

I have reviewed and updated this form. Signature_____ Date:_____/_____/_____

I have reviewed and updated this form. Signature_____ Date:_____/_____/_____

MEDICAL HISTORY