

So that we may provide you with the best possible care, it is important that you tell all dental personnel involved in your treatment about the general state of your health. Please complete this medical history form. This information is, of course, confidential.

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female
Address \_\_\_\_\_ Weight \_\_\_\_\_ Home Phone No. \_\_\_\_\_
Height \_\_\_\_\_ Work Phone No. \_\_\_\_\_
SSN # \_\_\_\_\_ Cell Phone No. \_\_\_\_\_

If you are completing this form for another person, what is your relationship to that person? Your Name \_\_\_\_\_ Relationship \_\_\_\_\_

MEDICAL HISTORY

Physician's Name \_\_\_\_\_

Address \_\_\_\_\_

Are you now under the care of a physician? YES  NO

If yes, for what reason? \_\_\_\_\_

Are you presently taking any medications / drugs / pills? YES  NO

ALLERGIES / SENSITIVITIES:

Are you allergic / sensitive (or ever had an adverse reaction) to: Check all that apply or check none

- Penicillin  Codeine  Local Anesthetic  Metals  LATEX
 Aspirin  Other Antibiotics  Other Medications or Substances  NONE

List all medications prescribed by your physician (including birth control pills), vitamins, herbal supplements, natural products, over-the-counter drugs taken routinely and controlled substances.

Do you have, or have you ever had any of the following: (YES or NO)

Table with 4 columns of conditions and YES/NO checkboxes. Conditions include: Artificial (prosthetic) heart valve, Previous infective endocarditis, Damaged valves in transplanted heart, Congenital heart disease (CHD), Heart murmur, Heart pacemaker, Rheumatic fever/heart disease, Mitral valve prolapse, High/low blood pressure, Learning Disability, Mental Health Disorder, Anorexia, Bulimia, Lung disease / COPD, Tuberculosis, Asthma, Shortness of Breath, Respiratory Ailments, Emphysema, Sinus Trouble, Diabetes Type I or Type II, Thyroid Problems, Persistent swollen glands, Kidney Problems, Venereal Disease, HIV Positive / AIDS / ARC, Alcohol Addiction, Drug Dependency, Chemical Dependency, Blood Disorders, Anemia, Leukemia, Prolonged Bleeding, Hemophilia, Sickle Cell Disease, Cancer, Tumors, Chemotherapy, Radiation Therapy, Neurological Disorders, Epilepsy, Stroke, Arthritis / Rheumatism, Autoimmune Disease, Artificial Joint / Prosthesis, Liver Disease, Hepatitis (circle one), Ulcers, Gastrointestinal Disease, GERD (gastric reflux), Hard of Hearing, Glaucoma, Cortisone Medication, Fainting Spells, Organ Transplant, Removal of Spleen, Osteoporosis, Sleep Disorder.

BISPHOSPHONATES

Have you ever or are you currently taking or scheduled to begin taking any of the medications, alendronate (Fosamax®), risedronate (Actonel®) or ibandronate (Boniva®) for osteoporosis or Paget's disease? YES  NO 
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? YES  NO  Date Treatment Began \_\_\_\_/\_\_\_\_/\_\_\_\_

DR COMMENTS

BLOOD PRESSURE

Have you ever used or currently use tobacco products? YES  NO  How much? \_\_\_\_\_ How Often? \_\_\_\_\_
How long ago did you quit? \_\_\_\_\_
Do you drink alcoholic beverages? YES  NO  How much? \_\_\_\_\_ How often? \_\_\_\_\_
Have you had any other serious illness, hospitalization or accident? YES  NO 
If yes, please explain \_\_\_\_\_

WOMEN: Are you pregnant or suspect that you may be? YES  NO 
Are you nursing? YES  NO

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_
(PARENT/GUARDIAN)

Doctor Signature \_\_\_\_\_ Date \_\_\_\_\_