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 ☐

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.

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**

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

	YES	NO		YES	NO		YES	NO		YES	NO
1 Artificial (prosthetic) heart valve	☐	☐	13 Anorexia	☐	☐	29 Drug Dependency	☐	☐	45 Autoimmune Disease	☐	☐
2 Previous infective endocarditis	☐	☐	14 Bulimia	☐	☐	30 Chemical Dependency	☐	☐	46 Artificial Joint / Prosthesis	☐	☐
3 Damaged valves in transplanted heart	☐	☐	15 Lung disease / COPD	☐	☐	31 Blood Disorders	☐	☐	47 Liver Disease	☐	☐
4 Congenital heart disease (CHD)			16 Tuberculosis	☐	☐	32 Anemia	☐	☐	48 Hepatitis (circle one)	☐	☐
Unrepaired, cyanotic CHD	☐	☐	17 Asthma	☐	☐	33 Leukemia	☐	☐	Type A B C Other		
Repaired (completely) in last 6 months	☐	☐	18 Shortness of Breath	☐	☐	34 Prolonged Bleeding	☐	☐	49 Ulcers	☐	☐
Repaired CHD with residual defects	☐	☐	19 Respiratory Ailments	☐	☐	35 Hemophilia	☐	☐	50 Gastrointestinal Disease	☐	☐
5 Heart Disease/Surgery	☐	☐	20 Emphysema	☐	☐	36 Sickle Cell Disease	☐	☐	51 GERD (gastric reflux)	☐	☐
6 Heart murmur	☐	☐	21 Sinus Trouble	☐	☐	37 Cancer	☐	☐	52 Hard of Hearing	☐	☐
7 Heart pacemaker	☐	☐	22 Diabetes Type I or Type II	☐	☐	38 Tumors	☐	☐	53 Glaucoma	☐	☐
8 Rheumatic fever/heart disease	☐	☐	23 Thyroid Problems	☐	☐	39 Chemotherapy	☐	☐	54 Cortisone Medication	☐	☐
9 Mitral valve prolapse	☐	☐	24 Persistent swollen glands	☐	☐	40 Radiation Therapy	☐	☐	55 Fainting Spells	☐	☐
10 High/low blood pressure	☐	☐	25 Kidney Problems	☐	☐	41 Neurological Disorders	☐	☐	56 Organ Transplant	☐	☐
11 Learning Disability	☐	☐	26 Venereal Disease	☐	☐	42 Epilepsy	☐	☐	57 Removal of Spleen	☐	☐
12 Mental Health Disorder	☐	☐	27 HIV Positive / AIDS / ARC	☐	☐	43 Stroke	☐	☐	58 Osteoporosis	☐	☐
			28 Alcohol Addiction	☐	☐	44 Arthritis / Rheumatism	☐	☐	59 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? _____

☐ cigarettes ☐ cigars ☐ pipe ☐ chew 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 _____