Name ______________________________________ Birthdate ____/____/____
Preferred Name ______________________________
Emergency Contact __________________________ Phone ________________

Medical History

Physician's Name:__________________________
Date of your last physical exam________________
Phone : ________________________________

Are you currently under medical care? Why? ________________
____
____

Please list any hospitalizations or major surgeries in the last five years: ____
____

Please list any **MEDICATIONS** you are currently taking including over the counter and herbal remedies**:**
____
____

Do you have allergies to any of the following?
Y N Latex   Y N Dental Anesthetics
Y N Penicillin   Y N Metals
Please list additional drugs that cause allergic or adverse reactions:________________________________
____

Do you **smoke/use tobacco** in any other form ❑ Yes ❑ No
Type and History________________________________
Have you ever taken **bisphosphonate** medications for conditions such as osteoporosis or osteopenia ❑ Yes ❑ No
Have you received IV **chemo** for cancer ❑ Yes ❑ No

For Women: Are you pregnant? ________________ Nursing?____________ Taking Birth Control Pills? _______________

Have you experienced or do you have any of the following medical conditions?

Y N AIDS/HIV+
Y N Anemia
Y N Anxiety/Depressio
Y N Artificial Heart Valve
Y N Arthritis
Y N Artificial Joints
Y N Antibiotic Premedication
Y N Asthma
Y N Back Problems
Y N Cancer
Y N Chemical Dependency
Y N Chemotherapy

Y N Chest Pain
Y N Circulatory Problem
Y N Congenital Heart Lesion
Y N Cortisone Treatments
Y N Diabetes Type_______
Y N Diet/Weight Loss
Y N Digestive disorder
Y N Epilepsy/Seizures
Y N Fainting/Dizziness
Y N Glaucoma
Y N Headaches
Y N Heart Attack

Y N Heart Conditions
Y N Hepatitis Type_______
Y N Herpes
Y N High Blood Pressure
Y N Hormone Treatment
Y N Immunological Conditions
Y N Kidney Disease
Y N Liver Disease
Y N Lung Disease
Y N Nervous Disorder
Y N Neurological Conditions
Y N Osteoporosis

Y N Prolonged Bleeding
Y N Pacemaker
Y N Psychiatric Care
Y N Radiation Treatment
Y N Sinus Conditions
Y N Stroke
Y N Swollen Glands
Y N Thyroid Problems
Y N Tumors or Growths
Y N Ulcers/Acid Reflux
Y N Sleep Apnea
Y N Viral Infections

List any medical condition, disease or problem not listed that you have experienced: ______________________________
____
____

I affirm that the information I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. Signature of

Patient, Parent or Guardian: ____**Date:**________________

History Review: