PATIENT NAME: _____ **MEDICAL HISTORY FORM**

All information is completely confidential

Your Physician's name:	**His/her phone number:**

Are you currently being treated for any illness? If yes, please describe:	Yes	No
Are you currently taking any medications? If yes, please list:	Yes	No
Are you or have you taken osteoporosis or cancer medications such as Fosamax, Boniva, Aredia, Zometa?	Yes	No
Do you need to pre-medicate with antibiotics prior to dental treatment?	Yes	No
Do you take daily aspirin?	Yes	No
Have you been hospitalized during the past 5 years? If yes, please describe:	Yes	No
Have you taken, or are taking recreational drugs? Type and frequency:	Yes	No
Do you consume alcohol? How much?	Yes	No
Tobacco in any form? How much?	Yes	No
Have you lost or gained more than 10 pounds in the past year?	Yes	No
For women: are you pregnant? How many months?	Yes	No
For Women: are you nursing?	Yes	No
are you taking birth control pills?	Yes	No

Have you ever had, or currently have any of the following?

Heart disease, surgery, attack	Yes	No	Arthritis, rheumatism	Yes	No	Psychiatric, psychological care	Yes	No
Heart defect	Yes	No	Fastin, pondimins	Yes	No	Hepatitis A, B, C,	Yes	No
Heart palpitation	Yes	No	Anemia	Yes	No	Cancer	Yes	No
Artificial heart valve	Yes	No	Recent eye surgery	Yes	No	Chemotherapy	Yes	No
Heart murmur	Yes	No	Swollen ankles	Yes	No	Tumors	Yes	No
Congenital heart disease	Yes	No	Fainting, dizzy spells	Yes	No	Venereal disease, AIDS, HIV	Yes	No
Mitral valve prolapse	Yes	No	Stroke	Yes	No	Herpes	Yes	No
Angina pectoris	Yes	No	Diet	Yes	No	AIDS, HIV	Yes	No
Rheumatic fever	Yes	No	Kidney trouble	Yes	No	Blood transfusion	Yes	No
High blood pressure	Yes	No	Gastric ulcer	Yes	No	Hemophilia	Yes	No
Chest pain	Yes	No	Diabetes	Yes	No	Sickle cell disease	Yes	No
Artificial joint, date:	Yes	No	Thyroid disease	Yes	No	Bruise easily	Yes	No
Respiratory disorder	Yes	No	Glaucoma	Yes	No	Liver disease	Yes	No
Tuberculosis, emphysema	Yes	No	Contact lens	Yes	No	Yellow jaundice	Yes	No
Chronic cough	Yes	No	Hay fever, allergy, hives	Yes	No	Epilepsy. Seizures	Yes	No
Asthma	Yes	No	Sinus trouble	Yes	No	Cold sores, fever blisters	Yes	No

Do you have any known allergy to any of the following medications?

Penicillin	Yes	No	Codeine, other narcotics	Yes	No	Local anesthetics	Yes	No
Erythromycin	Yes	No	Aspirin	Yes	No	Non-steroidal drugs	Yes	No
Tetracycline	Yes	No	Demerol	Yes	No	Anti-inflammatory drugs	Yes	No
Sulfa drugs	Yes	No	Barbiturates or sedatives	Yes	No	Latex	Yes	No
Other antibiotics	Yes	No	Other pain medications	Yes	No	Metals	Yes	No
Other:								

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

Patient/guardian/parent signature: _____ Date:_____

Health History updates. Please indicate changes below. If no changes, please indicate "no changes"

Changes: Patient's/Guardian signature:	Date:
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