# Medical History

Patient Name: Birth Date: Date Created:

| | | |
|---|---|---|
| Are you under a physician's care now? | Yes No | If yes |
| Have you ever been hospitalized or had a major operation? | Yes No | If yes |
| Have you ever had a serious head or neck injury? | Yes No | If yes |
| Are you taking any medications (including daily aspirin, vitamins, or supplements) | Yes No | If yes |
| Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? | Yes No | If yes |
| Do you use tobacco? | Yes No | If yes |
| Do you have any allergies? | Yes No | If yes |

Women

| | | |
|---|---|---|
| Are you pregnant? If yes, how many weeks? | Yes No | If yes |
| Are you taking oral contraceptives? | Yes No | |

Do you have, or have you had, any of the following?

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AIDS/HIV Positive | Yes No | Hemophilia | Yes No | Radiation Treatments | Yes No | Alzheimer's Disease | Yes No |
| Diabetes | Yes No | Hepatitis A | Yes No | Drug Addiction | Yes No | Hepatitis B or C | Yes No |
| Renal Dialysis | Yes No | Anemia | Yes No | Herpes | Yes No | Rheumatic Fever | Yes No |
| Emphysema | Yes No | High Blood Pressure | Yes No | Arthritis/Gout | Yes No | Epilepsy or Seizures | Yes No |
| High Cholesterol | Yes No | Scarlet Fever | Yes No | Artificial Heart Valve | Yes No | Excessive Bleeding | Yes No |
| Hives or Rash | Yes No | Shingles | Yes No | Artificial Joint | Yes No | Hypoglycemia | Yes No |
| Sickle Cell Disease | Yes No | Asthma | Yes No | Fainting Spells/Dizziness | Yes No | Irregular Heartbeat | Yes No |
| Sinus Trouble | Yes No | Kidney Problems | Yes No | Spina Bifida | Yes No | Leukemia | Yes No |
| Breathing Problems | Yes No | Liver Disease | Yes No | Stroke | Yes No | High Blood Pressure | Yes No |
| Swelling of Limbs | Yes No | Cancer | Yes No | Glaucoma | Yes No | Lung Disease | Yes No |
| Thyroid Disease | Yes No | Chemotherapy | Yes No | Hay Fever | Yes No | Mitral Valve Prolapse | Yes No |
| Chest Pains | Yes No | Heart Attack/Failure | Yes No | Osteoporosis | Yes No | Cold Sores/Fever Blister | Yes No |
| Heart Murmur | Yes No | Congenital Heart Disorder | Yes No | Heart Pacemaker | Yes No | Convulsions | Yes No |
| Heart Disease | Yes No | Psychiatric Care | Yes No | | | | |

| | | |
|---|---|---|
| Have you ever had any serious illness not listed | Yes No | If yes |

| | | |
|---|---|---|
| Have you had any change in your general health in the past year? | Yes No | If yes |

Antibiotic Pre-Med

| | | |
|---|---|---|
| **Do you require antibiotics before treatment?** | Yes No | If yes |

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____