MEDICAL HISTORY

To help us to provide you with the safest and best care, please complete this Medical History form. All information is kept strictly confidential

Have you taken any prescription drugs during the last 6 months? Please list **YES NO**

Are you taking any over the counter medications or herbal supplements? Please list: **YES NO**

Are you under a physician's care? If so, name and phone # of Physician: **YES NO**

Have you had any surgeries and/or hospitalization? **YES NO**

Are you now having or have you ever had radiation to the head or neck? **YES NO**

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Please list: **YES NO**

Have you ever taken bone density medications for cancer or osteoporosis? **YES NO**

Have you ever or are you currently taking blood thinners? **YES NO**

Do you use tobacco? What type and how much per day? **YES NO**

Do you drink alcohol? If so, how much and how often?

Do you use "street drugs"? If so, which ones? **YES NO**

Are you pregnant? **YES NO** | Taking birth control? **YES NO** | Plan to become pregnant? **YES NO** | Nursing? **YES NO**

Are you allergic to any of the following?

◯ Aspirin ◯ Penicillin ◯ Peanuts ◯ Codeine ◯ Acrylic ◯ Local Anesthetics
◯ Metal ◯ Latex ◯ Bananas ◯ Sulfa Drugs ◯ Other_____

Mark any of the following that are not or were previously applicable:

AIDS/HIV Positive	◯ YES ◯ NO	Convulsions	◯ YES ◯ NO	Hemophilia	◯ YES ◯ NO	Recent Weight Loss	◯ YES ◯ NO
Alzheimer's Disease	◯ YES ◯ NO	Cortisone Medicine	◯ YES ◯ NO	Hepatitis Type_____	◯ YES ◯ NO	Renal Dialysis	◯ YES ◯ NO
Anaphylaxis	◯ YES ◯ NO	Diabetes	◯ YES ◯ NO	Herpes	◯ YES ◯ NO	Rheumatic Fever	◯ YES ◯ NO
Anemia	◯ YES ◯ NO	Drug Addiction	◯ YES ◯ NO	High Blood Pressure	◯ YES ◯ NO	Rheumatism	◯ YES ◯ NO
Angina	◯ YES ◯ NO	Easily Winded	◯ YES ◯ NO	High Cholesterol	◯ YES ◯ NO	Scarlet Fever	◯ YES ◯ NO
Arthritis/Gout	◯ YES ◯ NO	Emphysema	◯ YES ◯ NO	Hives/Rash	◯ YES ◯ NO	Shingles	◯ YES ◯ NO
Artificial Heart Valve	◯ YES ◯ NO	Epilepsy/Seizures	◯ YES ◯ NO	Hypoglycemia	◯ YES ◯ NO	Sickle Cell Disease	◯ YES ◯ NO
Artificial Joint	◯ YES ◯ NO	Excessive Bleeding	◯ YES ◯ NO	Irregular Heartbeat	◯ YES ◯ NO	Sinus Trouble	◯ YES ◯ NO
Asthma	◯ YES ◯ NO	Excessive Thirst	◯ YES ◯ NO	Kidney Problems	◯ YES ◯ NO	Spina Bifida	◯ YES ◯ NO
Auto-Immune Disease	◯ YES ◯ NO	Fainting/Dizziness	◯ YES ◯ NO	Leukemia	◯ YES ◯ NO	Stomach Disease	◯ YES ◯ NO
Blood Disease	◯ YES ◯ NO	Frequent Cough	◯ YES ◯ NO	Liver Disease	◯ YES ◯ NO	Intestinal Disease	◯ YES ◯ NO
Blood Transfusion	◯ YES ◯ NO	Frequent Headaches	◯ YES ◯ NO	Low Blood Pressure	◯ YES ◯ NO	Stroke	◯ YES ◯ NO
Breathing Problems	◯ YES ◯ NO	Genital Herpes	◯ YES ◯ NO	Lung Disease	◯ YES ◯ NO	Swelling of Limbs	◯ YES ◯ NO
Bruise Easily	◯ YES ◯ NO	Glaucoma	◯ YES ◯ NO	Mitral Valve Prolapse	◯ YES ◯ NO	Thyroid Disease	◯ YES ◯ NO
Cancer	◯ YES ◯ NO	Hay Fever	◯ YES ◯ NO	Osteoporosis	◯ YES ◯ NO	Tonsillitis	◯ YES ◯ NO
Chemotherapy	◯ YES ◯ NO	Heart Attack/Failure	◯ YES ◯ NO	Pain in Jaw Joints	◯ YES ◯ NO	Tuberculosis	◯ YES ◯ NO
Chest Pains	◯ YES ◯ NO	Heart Murmur	◯ YES ◯ NO	Parathyroid Disease	◯ YES ◯ NO	Tumors/Growth	◯ YES ◯ NO
Cold Sores/Fever Blisters	◯ YES ◯ NO	Heart Pacemaker	◯ YES ◯ NO	Psychiatric Care	◯ YES ◯ NO	Ulcers	◯ YES ◯ NO
Congenital Heart Disorder	◯ YES ◯ NO	Heart Disease	◯ YES ◯ NO	Radiation Treatment	◯ YES ◯ NO	Venereal Disease	◯ YES ◯ NO
						Yellow Jaundice	◯ YES ◯ NO

Other, please explain:

Comments:

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 (or patient's) health. It is my responsibility to inform the office of any changes in medical status.

Print Patient Name

Signature of Patient or Guardian Date