

Medical History

Physician's Name _____ Date of Last Visit _____

Are you taking any medications, vitamins or herbal supplements? _____ Yes _____ No _____

Please List:

a. _____

b. _____

c. _____

Do you have any drug allergies or have an adverse reaction to any medications? _____ Yes _____ No _____ Don't Know _____

Please specify: _____

Reaction Type

Penicillin/Amoxicillin?	_____ Yes _____ No _____ Don't Know _____
Codeine?	_____ Yes _____ No _____ Don't Know _____
Anesthetics?	_____ Yes _____ No _____ Don't Know _____
Latex?	_____ Yes _____ No _____ Don't Know _____
Aspirin?	_____ Yes _____ No _____ Don't Know _____
Other?	_____ Yes _____ No _____ Don't Know _____

Have you ever responded adversely to medical or dental treatment? _____ Yes _____ No _____ Don't Know _____

Have you ever bled excessively? _____ Yes _____ No _____ Don't Know _____

Do you smoke or use any tobacco products? _____ Yes _____ No _____ Don't Know _____

Do you drink alcohol? (if yes, please indicate how many drinks per week) _____ Yes _____ No _____ Don't Know _____

Do you have anything artificial (pins, screws, valves, etc) implanted in your body? _____ Yes _____ No _____ Don't Know _____

Have you ever had a reaction to any type of metal? _____ Yes _____ No _____ Don't Know _____

Have you ever been told that you need antibiotics before dental treatment? _____ Yes _____ No _____ Don't Know _____

Have you had any type of surgery? Please List: _____ Yes _____ No _____ Don't Know _____

Do you use a C-Pap machine at night for sleep apnea? _____ Yes _____ No _____ Don't Know _____

Are you currently taking any medications for Osteoporosis or Osteopenia? _____ Yes _____ No _____ Don't Know _____

(Actonel, Boniva, Didronel, Fosamax, Fosamax plus D, Skelid, Aredia, Bonefos, Zometa, Reclast, Forteo)

List date and length of time these medications were used: _____

Do you have any other diagnosed conditions? _____ Yes _____ No _____ Don't Know _____

(Developmental, Genetic, Psychiatric, Physical)

If so, explain _____

Have you ever had head or neck radiation? _____ Yes _____ No _____ Don't Know _____

Females: Do you suspect you may be pregnant? _____ Yes _____ No _____ Don't Know _____

Are you nursing? _____ Yes _____ No _____ Don't Know _____

Have you ever had any of the following conditions? Please circle all that apply.

Infective Endocarditis	Blood Disease	Internal Shunts	Kidney Disease	Asthma
Heart Transplant	Stomach Ulcers	Stroke	Venereal Disease	Tuberculosis
Heart Attack	Immune Disorders	Lung Disease	Tumors/Growths	Hemophilia
Congenital Heart Problems	Unusual Numbness	Liver Disease	Blood Transfusion	Epilepsy
Artificial Joints	AIDS/HIV	Chemical Dependency	Cancer	Fainting Spells/Seizures
Heart Disease/Conditions	Artificial Heart Valves	Diabetes	Enlarged Heart	Hepatitis A B C D
High/Low Blood Pressure				

Notes _____

Patient Signature _____ Date _____