Patient Medical History

Name:____Date:________________

Primary Physician:___________________________________
Office Phone:______________________________________Date of Last Exam:_________________

□ Yes	□ No	Are you undergoing medical treatment?
□ Yes	□ No	Have you had any surgical procedures or serious illness? If yes, Please explain:____
□ Yes	□ No	Are you taking any medications including non-prescription medicine? If yes, please list:____
□ Yes	□ No	Have you ever taken Bisphosphonate drugs such as Aredia, Fosamax, Boniva, Actonel or Zometa?
□ Yes	□ No	Do you use tobacco or e-cigarettes?
□ Yes	□ No	Do you use controlled substances or recreational drugs? If yes, please specify:
		*Do you have or have you had any of the following?
□ Yes	□ No	Heart Disease
□ Yes	□ No	High Blood Pressure
□ Yes	□ No	Rheumatic Fever
□ Yes	□ No	Cardiac Pacemaker
□ Yes	□ No	Heart Murmur
□ Yes	□ No	Stroke
□ Yes	□ No	Mitral Valve Prolapse
□ Yes	□ No	Fainting/Seizures
□ Yes	□ No	Emphysema or Respiratory Problems
□ Yes	□ No	Hay Fever/Allergies/Sinus Problems
□ Yes	□ No	Asthma
□ Yes	□ No	Tuberculosis
□ Yes	□ No	Cancer (please specify):
□ Yes	□ No	Radiation Therapy (indicate areas):
□ Yes	□ No	Glaucoma
□ Yes	□ No	Diabetes
□ Yes	□ No	Kidney Diseases
□ Yes	□ No	Liver Diseases
□ Yes	□ No	Hepatitis (please specify type):

□ **Yes**	□ **No**	**Blood Disorders**
□ **Yes**	□ **No**	**Anemia**
□ **Yes**	□ **No**	**Arthritis**
□ **Yes**	□ **No**	**Joint Replacements (please list date of surgery):**
□ **Yes**	□ **No**	**Low Blood Pressure**
□ **Yes**	□ **No**	**Thyroid Problem**
□ **Yes**	□ **No**	**Stomach Troubles/Ulcers**
□ **Yes**	□ **No**	**HIV Immune Deficiencies**
□ **Yes**	□ **No**	**Sexually Transmitted Disease**
		***Other**
□ **Yes**	□ **No**	**Are you allergic to or have you had any reactions to any drugs or medications such as Penicillin or other antibiotics?** **Any other Allergies (please list)**____ ____ ____ ____
□ **Yes**	□ **No**	**Have you been advised to pre-medicate prior to dental treatment**
		***Women only**
□ **Yes**	□ **No**	**Are you pregnant or think you may be pregnant?**
□ **Yes**	□ **No**	**Are you nursing?**
□ **Yes**	□ **No**	**Are you taking oral contraceptives?**