

Medical Information

Are you now under the care of a physician? [] Yes [] No

Physician Name:

Phone:

Fax:

Address :

City:

State:

Zip:

Are you in good health? [] Yes [] No

Has there been any change in your general health in the past year?

If yes, what condition was treated?

Date of your last physical exam:

Do you wear contact lenses? [] Yes [] No

Are you taking, or have you taken any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine), or fen-phen (fenfluramine-phentermine combination)? [] Yes [] No

Are you taking or scheduled to begin taking either of the medications alendronate (Fosamax) or risendronate (Actonel) for osteoporosis or Paget's disease? [] Yes [] No

Were you treated with or are you presently scheduled to begin treatment with the intravenous biophosphonates (Aredia or Zometa) for bonepain, hypercalcemia, or skeletal complications resulting from Paget's disease, multiple myeloma, or metastatic cancer? [] Yes [] No

Date treatment began:

Have you has a serious illness, operation or been hospitalized in the last 5 years? [] Yes [] No
If yes what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)? [] Yes [] No

If yes, Please list all, including vitamins, natural or herbal preparations and/or diet supplements:

Do you use controlled substances or drugs? [] Yes [] No

Do you use tobacco (Smoking, snuff, chew, bidis) [] Yes [] No
If so, how interested are you in stopping?
[] Very [] Somewhat [] Not Interested

Do you drink alcoholic beverages? [] Yes [] No

How much alcohol did you drink in the last 24 hours?

How much do you typically drink in a week?

Women Only Are you:
Pregnant? [] Yes [] No Number of weeks:
Nursing? [] Yes [] No

Taking birth control pills or hormone replacement? [] Yes [] No

Joint Replacement. Have you had an orthopedic total joint replacement (hip, knee, elbow, finger)? [] Yes [] No Date:

If yes, list complications:

Allergies – Please check all that apply and specify reaction for each checked allergies.

[] Local anesthetic:

[] Aspirin:

[] Penicillin or other antibiotics:

[] Barbituates, sedatives, or sleeping pills:

[] Sulfa drugs:

[] Codeine or other narcotics:

[] Metals:

[] Latex (rubber):

[] Iodine:

[] Hay fever / seasonal:

[] Animals:

[] Food:

[] Other:

Heart murmur [] Y [] N

Anemia [] Y [] N

Chest pain upon exertion [] Y [] N

Neurological disorders [] Y [] N

Mitral valve prolapse [] Y [] N

Blood transfusion [] Y [] N

Chronic pain [] Y [] N

If yes specify:

Artificial heart valves [] Y [] N

If yes, date:

Diabetes - Type I or II [] Y [] N

Sleep disorder [] Y [] N

Rheumatic fever [] Y [] N

Hemophilia [] Y [] N

Eating disorder [] Y [] N

Mental health disorder [] Y [] N

Cardiovascular disease [] Y [] N

AIDS or HIV infection [] Y [] N

Malnutrition [] Y [] N

If yes, specify:

Angina [] Y [] N

Arthritis [] Y [] N

Gastrointestinal disease [] Y [] N

Recurrent infections [] Y [] N

Arteriosclerosis [] Y [] N

Autoimmune disease [] Y [] N

G.E. Reflux / Persistent heartburn [] Y [] N

Type of infection:

Congestive heart failure [] Y [] N

Rheumatoid Arthritis [] Y [] N

Ulcers [] Y [] N

Kidney problems [] Y [] N

Coronary heart disease [] Y [] N

Systemic lupus erythematosus [] Y [] N

Thyroid problems [] Y [] N

Night sweats [] Y [] N

Damaged heart valves [] Y [] N

Asthma [] Y [] N

Stroke [] Y [] N

Osteoporosis [] Y [] N

Heart Attack [] Y [] N

Bronchitis [] Y [] N

Glaucoma [] Y [] N

Persistent swollen glands in the neck [] Y [] N

Low blood pressure [] Y [] N

Emphysema [] Y [] N

Hepatitis, jaundice, or Liver disease [] Y [] N

Severe headaches / Migraines [] Y [] N

High blood pressure [] Y [] N

Sinus trouble [] Y [] N

Epilepsy [] Y [] N

STD's [] Y [] N

Congenital heart defects [] Y [] N

Tuberculosis [] Y [] N

Fainting spells or seizures [] Y [] N

Sever or rapid weight loss [] Y [] N

Pacemaker [] Y [] N

Cancer, chemotherapy, or Radiation treatment [] Y [] N

Excessive urination [] Y [] N

Rheumatic heart disease [] Y [] N

Abnormal bleeding [] Y [] N

Has any physician or dentist recommended that you take antibiotics prior to your dental treatment? [] Y [] N

Name of the physician or dentist making recommendation:

Do you have any disease, condition, or problem not listed above that you think your dentist should know about? [] Y [] N

Please explain:

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any other member of his/her staff, responsible for any action that they take or do not take because of errors or omissions that I have made in completion of this form.

Date: _____

Signature of Patient / Legal Guardian: _____