MEDICAL HISTORY

Patient's Name: _____

Are you in good health? ❑Y ❑N Have you ever had any serious illness requiring hospitalization or surgery? ❑Y ❑N

Height: _____ ft _____ in Weight _____ lbs

Do you have-or-have you ever had any of the following?

High blood pressure ..... ❑Y ❑N
Diabetes mellitus ..... ❑Y ❑N
Heart problems..... ❑Y ❑N
Heart attack..... ❑Y ❑N
Heart surgery ..... ❑Y ❑N
Pacemaker ..... ❑Y ❑N
Lung disease..... ❑Y ❑N
Asthma..... ❑Y ❑N
COPD/Emphysema..... ❑Y ❑N
Stroke..... ❑Y ❑N
Seizures/Epilepsy ..... ❑Y ❑N
Alzheimer's/Dementia ..... ❑Y ❑N
Autoimmune disease ..... ❑Y ❑N
Thyroid disease ..... ❑Y ❑N
Eye disease ..... ❑Y ❑N

Cancer ..... ❑Y ❑N
Chemotherapy ..... ❑Y ❑N
Radiation treatment ..... ❑Y ❑N
Kidney disease ..... ❑Y ❑N
Hepatitis A,B,C ..... ❑Y ❑N
Ulcers/Acid reflux ..... ❑Y ❑N
Organ transplant ..... ❑Y ❑N
Anemia/Blood Disorder ..... ❑Y ❑N
Osteoporosis ..... ❑Y ❑N
Arthritis ..... ❑Y ❑N
Sinus/Nasal problems ..... ❑Y ❑N
Sleep apnea/Loud snoring.. ❑Y ❑N
TMJ problems ..... ❑Y ❑N
STDs/Herpes/HPV..... ❑Y ❑N
HIV/AIDS ..... ❑Y ❑N

Psychiatric care ..... ❑Y ❑N
Anorexia/Bulemia ..... ❑Y ❑N
Do you smoke..... ❑Y ❑N
History of alcohol / drug dependence..... ❑Y ❑N
Do you use illicit / recreational drugs..... ❑Y ❑N
Implants such as heart valve, hip, knee, etc ..... ❑Y ❑N
Have you ever been told to premedicate with antibiotics before dental treatment..... ❑Y ❑N
Personal/Family History of Malignant Hyperthermia..... ❑Y ❑N

Do you have any medical problems not covered above? ❑Y ❑N If yes please list: _____

_____

List all medications you are taking:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Have you ever taken any of the following medications?

Aredia (Pamidronate) ..... ❑Y ❑N
Zometa (Zolendronate) ..... ❑Y ❑N
Fosamax (Alendronate) ..... ❑Y ❑N
Boniva (Ibandronate) ..... ❑Y ❑N
Actonel (Risedronate) ..... ❑Y ❑N
Reclast (Zolendronate) ..... ❑Y ❑N
Xgeva (Denosumab)..... ❑Y ❑N
Prolia ..... ❑Y ❑N

Are you allergic to - or - have you had an adverse reaction to any of the following?

Local Anesthesia ..... ❑Y ❑N
Penicillin ..... ❑Y ❑N
Sulfa Drugs ..... ❑Y ❑N
Codeine ..... ❑Y ❑N
Latex ..... ❑Y ❑N
Eggs ..... ❑Y ❑N
Soy ..... ❑Y ❑N

List other allergies:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

For Women

Are You pregnant? ..... ❑Y ❑N
Are you nursing? ..... ❑Y ❑N
Are you taking birth control pills?..... ❑Y ❑N

**** ALERT:***
Medications such as antibiotics can decrease the effectiveness of birth control pills. It is recommended that an additional form of birth control be used for one full cycle after stopping medications.

I certify that all information provided above is true and accurate to the best of my knowledge. I authorize the doctors and staff to perform examinations and x-rays necessary for diagnosis and treatment planning.

Patient's (Legal Guardian's) Signature: _____ Date: _____