Name_____Date of Birth___/___/_____

Patient Medical History

Physicians Name & Date of most recent exam:_____Are you under medical treatment now? _____Yes_____No

If Yes Explain_____

Have you ever been hospitalized for surgical operations or illness? _____Yes_____No

If Yes Explain_____

Are you taking any medication(s)? _____Yes_____No If Yes please list:

_____

Do you use tobacco? ____Yes ____No

Women only: Are you pregnant or think you may be pregnant? ____Yes ____No

Do you take antibiotic premedication for your dental visits? _____Yes_____No If yes, please explain.

_____

Are you allergic to or have you had any reactions to the following: Please Circle Y or N:

Y	N	Local Anesthesia
Y	N	Penicillin or other antibiotics
Y	N	Sulfa Drugs
Y	N	Sedatives
Y	N	Aspirin
Y	N	Other:

Do you use recreational drugs? (ie: Cocaine, etc.) ____Yes ____No

Have you ever taken Bisphosphonates (ie: Boniva, Fosamax, Reclast, Actonel) ____Yes____No

Do you have or are you being treated for any of the following? Please check:

- □ High Blood Pressure
- □ Low Blood Pressure
- □ Artificial Heart Valve
- □ Heart Attack
- □ Heart Disease
- □ Heart Murmur
- □ Chest Pains
- □ Angina
- □ Stroke
- □ Joint Replacement/Implants
- □ Chemotherapy
- □ Fainting/Seizures
- □ Rheumatic Fever
- □ Anemia
- □ Tuberculosis
- □ Radiation Therapy
- □ Glaucoma
- □ Leukemia
- □ Emphysema
- □ Hepatitis/Jaundice
- □ Aids or HIV Infection
- □ Bleeding Disorders
- □ Cancer
- □ Liver Disease
- □ Hay Fever/Allergies
- □ Asthma
- □ Hemophilia
- □ Epilepsy/Convulsions
- □ Diabetes
- □ Kidney Disease
- □ Respiratory Problems
- □ High Cholesterol
- □ Lyme Disease

Please list any other medical conditions_____

Patient Dental History

When was your last dental visit?_____

Do you have any dental concerns?_____

The above questions have been accurately answered and up to date to the best of my knowledge.

Signature_____Date____/____/_____