



MEDICAL HISTORY

Welcome! So that we may provide you with the best possible care, please complete both sides of this medical and dental history form. All information is completely confidential.

PATIENT'S NAME: _____

Have you been under the care of a medical doctor during the past two years? Yes No

If yes, for what? _____

Physician's Name _____ Telephone _____
Address _____ City _____ State _____ Zip _____

Are you currently taking any medications, drugs or pills? Yes No

If yes, please list name and dosage: _____

Have you ever had an allergic or adverse reaction to any medication or substance (including foods)? Yes No

If yes, please list: _____

Circle Yes or No to indicate whether or not you have had or now have the following conditions or treatments:

- | | | |
|---|--|---|
| Heart Condition Yes / No | Contact Lenses Yes / No | Cortisone Medicine Yes / No |
| Heart Attack Yes / No | Glaucoma Yes / No | Arthritis/Rheumatism Yes / No |
| Heart Surgery Yes / No | Bruise Easily Yes / No | Fen-Phen or Redox Yes / No |
| Chest Pain (Angina) Yes / No | Emphysema Yes / No | Special or Restricted Diet Yes / No |
| Congenital Heart Disease Yes / No | Chronic Cough Yes / No | Latex Sensitivity Yes / No |
| Stroke Yes / No | Tuberculosis (T.B.) Yes / No | Cancer Yes / No |
| High Blood Pressure Yes / No | Asthma Yes / No | Tumors Yes / No |
| Mitral Valve Prolapse Yes / No | Hay Fever Yes / No | Chemotherapy Yes / No |
| Artificial Heart Valve Yes / No | Sinus Trouble Yes / No | Radiation Therapy Yes / No |
| Rheumatic Fever Yes / No | Allergies or Hives Yes / No | Neurological Disorders Yes / No |
| Heart Murmur Yes / No | Liver Disease Yes / No | Nervous/Anxious Yes / No |
| Heart Pacemaker Yes / No | Hepatitis Type _____ Yes / No | Epilepsy or Seizures Yes / No |
| Anemia Yes / No | Yellow Jaundice Yes / No | Fainting or Dizzy Spells Yes / No |
| Hemophilia Yes / No | AIDS Yes / No | Psychiatric/Psychological Care Yes / No |
| Ulcers Yes / No | HIV Positive Yes / No | Kidney Trouble Yes / No |
| Alcoholism Yes / No | Venereal Disease Yes / No | Artificial Joints or Heart Valves... Yes / No |
| Drug Addiction Yes / No | Cold Sores/Fever Blisters Yes / No | Sickle Cell Disease Yes / No |
| Diabetes Yes / No | Blood Transfusion Yes / No | Osteoporosis Yes / No |
| Family History of Diabetes Yes / No | Thyroid Problems Yes / No | Bone Disease or Bone Cancer... Yes / No |
| | Swollen Ankles Yes / No | |

Do you have or have you had any disease, condition or problem not listed Yes No

If yes, please list: _____

Have you ever had prolonged or unusual bleeding? Yes No

Are you taking or have you ever taken any of the following medications: Aredia (pamidronate), Zometa (zoledronic acid), Bonifos (clodronate), Actonel (risedronate), Boniva (ibandronate), Fosamax (alendronate), Skelid (tiludronate), Didronel (etidronate)..... Yes No

Have you ever had a reaction to a local anesthetic? Yes No

Do you use more than two pillows to sleep? Yes No

Do you experience frequent thirst, frequent eating or frequent urination? Yes No

Women: Are you pregnant?...Yes No If yes, due date: _____ Nursing?...Yes No Taking birth control pills?...Yes No

(Please complete the other side)