Patient Name___________________________________ Date of Birth________________

Medical History

Are you under the care of a physician? Y/N If yes:____

Have you ever been hospitalized or had major operation? Y/N If yes:_______________________________________

Have you ever had a serious head or neck injury? Y/N If yes:____

Do you use tobacco? Y/N

Do you use any controlled substances? Y/N

Have you ever taken a bisphosphonate medication such as Fosamax, Boniva, or Actonel? Y/N

Please list any current medications: ____

____

Are you allergic to any medications (such as aspirin, penicillin, sulfa drugs, codeine, etc) or Latex? Y/N

Please list: ____

Have you had or do you have any of the following:

	Y	N		Y	N		Y	N
AIDS/HIV Positive			Epilepsy or Seizures			Low Blood Pressure		
Alzheimer's Disease			Excessive Bleeding			Lung Disease		
Anaphylaxis			Fainting/Dizziness			Mitral Valve Prolapse		
Anemia			Frequent Cough			Osteoporosis		
Angina/Chest Pains			Frequent Diarrhea			Pain in Jaw Joints		
Artificial Heart Valve			Frequent Headaches			Parathyroid Disease		
Artificial Joint			Heart Attack/Failure			Psychiatric Care		
Asthma			Heart Murmur			Radiation Treatment		
Blood Disease			Heart Pacemaker			Recent Weight Loss		
Blood Transfusion			Heart Disease			Renal Dialysis		
Breathing Problems			Hemophilia			Sinus Trouble		
Bruise Easily			Hepatitis A			Stomach Disease		
Cancer			Hepatitis B or C			Stroke		
Chemotherapy			Herpes			Swelling of Limbs		
Cold Sores			High Blood Pressure			Thyroid Disease		
Congenital Heart Disorder			Hives or Rash			Tonsillitis		
Cortisone Medications			Hypoglycemia			Tuberculosis		
Diabetes			Kidney Problems			Ulcers		
Drug Addiction			Leukemia			Venereal Disease		
Emphysema			Liver Disease					
Any other serious illness?			If yes, please explain: ____ ____					

Females Only: Are you:

Pregnant/Potentially Pregnant? Y/N

Nursing? Y/N

Taking Oral Contraceptives? Y/N

If pregnant, what is your due date? ____________________________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient Signature ____ Date________________