MEDICAL HISTORY

Patient Name	**Health Alert**	**BP:**

1. Have you been under the care of a medical doctor during the past 2 years? Yes No
   If yes, for what? ____
   Physician's Name ____ Phone _________________

2. Have you taken any medication / drugs during the past two years? Yes No

3. Are you taking any medication, drugs, or pills now? Yes No
   If yes, please list name and dosage ____

4. Have you been a patient in the hospital during the past 5 years? Yes No

5. Do you require antibiotics before dental treatment Yes No

6. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each of them.

Tuberculosis	Yes	No	Cortisone Medicine	Yes	No	High / Low Blood Pressure	Yes	No
Asthma	Yes	No	Swollen Ankles	Yes	No	HIV+ / AIDS	Yes	No
Hay Fever	Yes	No	Venereal Disease	Yes	No	Rheumatic / Scarlet Fever	Yes	No
Stroke	Yes	No	Allergies /Hives	Yes	No	Anemia / Radiation Treatment	Yes	No
Arthritis	Yes	No	Blood Transfusion	Yes	No	Cancer / Chemotherapy	Yes	No
Diabetes	Yes	No	Difficulty Breathing	Yes	No	Congenital Heart Defect	Yes	No
Heart Murmur	Yes	No	Drug / Alcohol Abuse	Yes	No	Epilepsy or Seizures	Yes	No
Shingles	Yes	No	Sickle Cell Disease	Yes	No	Severe Frequent Headaches	Yes	No
Sinus Problems	Yes	No	Heart Attack/ Stroke	Yes	No	Heart Surgery / Pacemaker	Yes	No
Ulcer / Colitis	Yes	No	Psychiatric Problem	Yes	No	Mitral Valve Prolapsed	Yes	No
Hepatitis	Yes	No	Kidney Problems	Yes	No	Hemophilia/Abnormal Bleeding	Yes	No
Glaucoma	Yes	No	Nervous/Anxious	Yes	No	Anemia/Radiation Treatment	Yes	No
Liver Disease	Yes	No	Thyroid Problems	Yes	No	Artificial Joints / Hip / Knee	Yes	No
Emphysema	Yes	No	Bruise Easily	Yes	No	Artificial Bones /Joints / Valves	Yes	No

7. Do you have or have you had any disease condition, or problem not listed above? Yes No
   If yes, please list: ____

8. **Women** Are you: Pregnant? Yes, ________ Months No **Nursing** Yes No
   Taking birth control pills? Yes No

9. Do you smoke or use tobacco in any form? Yes No

10. Have you ever taken Fosamax, or any other bisphosphonate? Yes No

I understand the above information is necessary to provide me with dental care in a safe & efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Patient Signature____ Date _______________

OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein.

Doctor's Signature ______________________________________ Date ___________

Doctor's Comments: ____

____

Medical History Update

1. Date: ____________ Comments: ____ Signature ____________
2. Date: ____________ Comments: ____ Signature ____________
3. Date: ____________ Comments: ____ Signature ____________