PATIENT NAME_____ **MEDICAL HISTORY**

1. Have you been under the care of a medical doctor during the past two years?.....Yes No
   If yes, for what?_____
   Physician's Name_____ Phone_____
   Address_____ City_____ State_____ Zip_____
2. Have you taken any medication or 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. Are you aware of having an allergic or adverse reaction to any medication, dental anesthetic or substance?.....Yes No
   If yes, please list_____
5. Have you been a patient in the hospital during the past five years?.....Yes No

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

Heart (Surgery, Disease, Attack)..... Yes No	Venereal Disease..... Yes No	Thyroid problems..... Yes No
Chest Pain..... Yes No	A.I.D.S..... Yes No	Glaucoma..... Yes No
Congenital Heart Disease..... Yes No	H.I.V. Positive..... Yes No	Contact Lenses..... Yes No
Heart Murmur..... Yes No	Cold Sores/Fever Blisters ..... Yes No	Emphysema..... Yes No
High/Low Blood Pressure..... Yes No	Blood Transfusion.....Yes No	Chronic Cough..... Yes No
Mitral Valve Prolapse..... Yes No	Hemophilia..... Yes No	Tuberculosis..... Yes No
Artificial Heart Valve.....Yes No	Sickle Cell Disease..... Yes No	Asthma..... Yes No
Heart Pacemaker.....Yes No	Bruise Easily..... Yes No	Hay Fever..... Yes No
Rheumatic Fever.....Yes No	Liver Disease..... Yes No	Gold or Metal Allergy..... Yes No
Arthritis/Rheumatism.....Yes No	Yellow Jaundice..... Yes No	Red Dye Allergy..... Yes No
Cortisone Medicine..... Yes No	Neurological Disorders..... Yes No	Acrylic Allergy..... Yes No
Swollen Ankles..... Yes No	Epilepsy or Seizures.....Yes No	Latex Allergy..... Yes No
Stroke.....Yes No	Fainting or Dizzy Spells.....Yes No	Allergies or Hives..... Yes No
Diet (Special/Restricted)..... Yes No	Nervous/Anxious..... Yes No	Sinus Trouble.....Yes No
Artificial Joints..... Yes No	Psychiatric/Psychological Care..... Yes No	Radiation Therapy.....Yes No
Kidney Trouble..... Yes No	Ulcers..... Yes No	Chemotherapy..... Yes No
Hepatitis A (infectious) B (Serum).....Yes No	Diabetes/Hypoglycemia..... Yes No	Tumors/Cancer..... Yes No

6. Have you or are you receiving any drugs intravenously, such as: Zometa or Aredia, Other_____
   Who is your physician who monitors these biophosphonate drugs for you?
   Name_____ Phone_____ Name_____ Phone_____
7. Do you use more than two pillows to sleep?.....Yes No
8. Have you gained or lost more than 10 pounds in the past year?.....Yes No
9. Do you have or have you had any disease, condition or problem not listed?.....Yes No
   If yes, please list:_____
10. **Women,** Are you: **Pregnant?** Yes____Months **Nursing?** Yes No **Taking birth control pills?** Yes No
11. Do you use tobacco? **Yes No** If yes, how used?_____How often?_____How long?_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered 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.

Patient/Guardian Signature_____ Date_____

HISTORY REVIEW

PMH:

MEDS:

ALLERGIES:

Dentist Signature:_____ Date_____