

Date: _____

MEDICAL HISTORY

Patient Name: _____

Birth Date: _____

Are you under a physician's care now?	☐ Yes ☐ No
Have you ever been hospitalized or had a major operation?	☐ Yes ☐ No
Have you ever had a serious head or neck injury?	☐ Yes ☐ No
Do you take, or have you taken, Phen-Fen or Redux?	☐ Yes ☐ No
Have you ever taken Fosamax or any other medications containing bisphosphonates?	☐ Yes ☐ No
Are you on a special diet?	☐ Yes ☐ No
Do you use tobacco?	☐ Yes ☐ No
Do you use controlled substances?	☐ Yes ☐ No

If you answered Yes to any of the questions, please explain:

Do you have, or have you had, any of the following?

Under Medical Treatment ☐ Yes ☐ No	Fatigue ☐ Yes ☐ No	TMJ/Jaw ☐ Yes ☐ No
Dry Mouth ☐ Yes ☐ No	Swelling ☐ Yes ☐ No	Heart Disease ☐ Yes ☐ No
High Blood Pressure ☐ Yes ☐ No	Overweight ☐ Yes ☐ No	Heart Murmur/Defect ☐ Yes ☐ No
Respiratory/Asthma ☐ Yes ☐ No	Underweight ☐ Yes ☐ No	Pacemaker ☐ Yes ☐ No
Rheumatic Fever ☐ Yes ☐ No	Thyroid/Hormonal ☐ Yes ☐ No	Heart Attack/Stroke ☐ Yes ☐ No
Immunocompromised ☐ Yes ☐ No	Ulcers/Digestive ☐ Yes ☐ No	Systemic Lupus ☐ Yes ☐ No
Anemia/Bleeding ☐ Yes ☐ No	Migraine/Headaches ☐ Yes ☐ No	Prosthetic Implant ☐ Yes ☐ No
Diabetes/Kidney ☐ Yes ☐ No	Epilepsy/Fainting ☐ Yes ☐ No	Any Transplant ☐ Yes ☐ No
Herpes ☐ Yes ☐ No	Glaucoma/Visual ☐ Yes ☐ No	Joint Replacement ☐ Yes ☐ No
Hypoglycemia ☐ Yes ☐ No	Mental/Neural ☐ Yes ☐ No	Arthritis ☐ Yes ☐ No
Smoke/Tobacco ☐ Yes ☐ No	Tumor/Neoplasms ☐ Yes ☐ No	Pregnant/Nursing ☐ Yes ☐ No
Shortness of Breath ☐ Yes ☐ No	Alcoholism/Addiction ☐ Yes ☐ No	Previous Root Canal ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	Infectious Diseases ☐ Yes ☐ No	Excessive Bleeding ☐ Yes ☐ No
Radiation/Chemo ☐ Yes ☐ No	Venereal Disease ☐ Yes ☐ No	Poor Dental Hygiene ☐ Yes ☐ No
Tuberculosis ☐ Yes ☐ No	Psychiatric Care ☐ Yes ☐ No	

Are you allergic to any of the following?

Penicillin/Amoxicillin	☐ Yes ☐ No	Food	☐ Yes ☐ No
Antibiotics	☐ Yes ☐ No	Bleach	☐ Yes ☐ No
Aspirin	☐ Yes ☐ No	Iodine/Seafood	☐ Yes ☐ No
Tylenol	☐ Yes ☐ No	Milk	☐ Yes ☐ No
Sulfa	☐ Yes ☐ No	Sleeping Pills	☐ Yes ☐ No
Narcotics	☐ Yes ☐ No	Metal	☐ Yes ☐ No
Local Anesthesia	☐ Yes ☐ No	Seasonal	☐ Yes ☐ No
Latex	☐ Yes ☐ No	Mold	☐ Yes ☐ No
Valium/Tranquil.	☐ Yes ☐ No	Sulfite	☐ Yes ☐ No
Nitrous	☐ Yes ☐ No	Other	☐ Yes ☐ No

Are you taking any of the following medications?

Antibiotics	☐ Yes ☐ No	Birth Control Pills	☐ Yes ☐ No
Pain Medicine	☐ Yes ☐ No	Insulin	☐ Yes ☐ No
Heart Medicine	☐ Yes ☐ No	Ulcer/Nexium	☐ Yes ☐ No
Aspirin	☐ Yes ☐ No	Bone Related	☐ Yes ☐ No
Cortisone	☐ Yes ☐ No	Antidepressants	☐ Yes ☐ No
Blood Thinner	☐ Yes ☐ No	Asthma/COPD	☐ Yes ☐ No
Blood Pressure	☐ Yes ☐ No	Infectious	☐ Yes ☐ No
Hormone	☐ Yes ☐ No	Seasonal	☐ Yes ☐ No
Thyroid	☐ Yes ☐ No	Vitamins	☐ Yes ☐ No

Please list any additional medication and dosage

I understand that withholding any information about my health could seriously jeopardize my safety. Therefore I have reviewed this health history carefully and have answered all questions to the best of my knowledge.

Signature of Patient, Parent or Guardian

Date