

Patient First Name _____

Patient Last Name _____

Date _____

MEDICAL HISTORY

Although dental personnel primary treat the area in and around your mouth, your mouth is a part of your entire body, health problems that you may have, or medication.

Are you currently under a physicians care | Yes No

Do you have a history of osteopenia, osteoporosis or other bone disease | Yes No

Have you ever had surgery | Yes No

Have you ever had to take a pre-med | Yes No

Are you or have you in the past been treated with Bisphosphonates for the treatment of bone density, metastatic cancer, or Pagets disease | Yes No

Are you or will you be having treatment or impeding surgery that could possibly affect your dental treatment | Yes No

WOMEN, Are you currently: Pregnant Trying to get pregnant Nursing Taking oral contraceptives

ALLERGIES, check all that apply

- | | | | |
|--|--|---|---------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Barbiturates (sleeping pills) | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Iodine | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Other Antibiotics | <input type="checkbox"/> Food Allergies | <input type="checkbox"/> NSAIDS |
| <input type="checkbox"/> Tylenol | <input type="checkbox"/> No know Allergies | | |

List any additional allergies that may not be listed | _____

MEDICATIONS, please list the medications you are currently taking |

_____	_____
_____	_____
_____	_____

Indicate which of the following you have had or have at present, by checking the "YES" or "NO" box.

YES	NO		YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness Fainting	<input type="checkbox"/>	<input type="checkbox"/>	MI/heart attack
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disease
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis, Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Elevated Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker
<input type="checkbox"/>	<input type="checkbox"/>	Artificial heart valves	<input type="checkbox"/>	<input type="checkbox"/>	Generalized anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric care
<input type="checkbox"/>	<input type="checkbox"/>	Artificial joints	<input type="checkbox"/>	<input type="checkbox"/>	GI Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Radiation treatment
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Head Injuries	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory problems
<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune disorder	<input type="checkbox"/>	<input type="checkbox"/>	Head and neck cancer	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism
<input type="checkbox"/>	<input type="checkbox"/>	Back problems	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever
<input type="checkbox"/>	<input type="checkbox"/>	Blood disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet fever
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes or Family History	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Sinus problems
<input type="checkbox"/>	<input type="checkbox"/>	CPAP/sleep disorder	<input type="checkbox"/>	<input type="checkbox"/>	Heart stent	<input type="checkbox"/>	<input type="checkbox"/>	Skin rash
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis (type ____)	<input type="checkbox"/>	<input type="checkbox"/>	Special Diet
<input type="checkbox"/>	<input type="checkbox"/>	Chemical dependency	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Swollen neck glands
<input type="checkbox"/>	<input type="checkbox"/>	Circulatory problems	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Smoking
<input type="checkbox"/>	<input type="checkbox"/>	Clotting disorder	<input type="checkbox"/>	<input type="checkbox"/>	Jaw pain	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis
<input type="checkbox"/>	<input type="checkbox"/>	C-Difficile	<input type="checkbox"/>	<input type="checkbox"/>	Joint replacement	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Congenital heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Tumors
<input type="checkbox"/>	<input type="checkbox"/>	Cortisone treatments	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes or family history	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer
<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease			