MEDICAL HISTORY

Patient's Name _____

Last First Initial DOB

CIRCLE THE APPROPRIATE ANSWER, IF YOU DON'T KNOW THE ANSWER PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

1.	Physician's Name_____ Tel: (_____)_____ Address		
2.	Are you under a physician's care? Since when Why	YES	NO
3.	When was your last complete physical exam?		
4.	Are you taking any medications? (If yes, please list medications in the comment section, or on the back of this form.	YES	NO
5.	Do you take any health-related substances? Vitamins, herbal supplements	YES	NO
6.	Are you allergic to any medications or substances? (please list)	YES	NO
7.	Do you have any other allergies or hives?	YES	NO
8.	Do you have any problems with local anesthetics, penicillin or other antibiotics, sulfa drugs, aspirin, tylenol, ibuprofen, codeine, sedatives	YES	NO
9.	Are you sensitive to any metals or latex?	YES	NO
10.	Have you ever been treated for or been told you have heart disease?	YES	NO
11.	Do you have a pacemaker or an artificial heart valve implant?	YES	NO
12.	Have you ever had rheumatic fever?	YES	NO
13.	Are you aware of any heart murmurs?	YES	NO
14.	Do you have high or low blood pressure? (please circle)	YES	NO
15.	Have you ever had a serious illness or major surgery?	YES	NO
16.	Have you EVER had radiation treatment or chemotherapy?	YES	NO
17.	Do you have inflammatory diseases, such as arthritis or rheumatism?	YES	NO
18.	Do you have any artificial joints/prosthesis?	YES	NO
19.	Do you have any blood disorders, such as anemia, leukemia, etc?	YES	NO
20.	Have you ever bled excessively after being cut or injured?	YES	NO
21.	Do you have any stomach problems? Ulcers, special diet	YES	NO
22.	Do you have any kidney problems?	YES	NO
23.	Do you or have you had hepatitis, jaundice, or liver problems?	YES	NO
24.	Are you diabetic?	YES	NO
25.	Do you have fainting or dizzy spells?	YES	NO
26.	Do you have asthma?	YES	NO
27.	Do you have epilepsy or seizure disorders?	YES	NO
28.	Do you or have you had herpes or other STD?	YES	NO
29.	Have you tested HIV positive? Do you have AIDS?	YES	NO
30.	Do you or have you had TB?	YES	NO
31.	Do you smoke, chew, use snuff or any other forms of tobacco	YES	NO
32.	Do you consume alcoholic beverages?	YES	NO
33.	Do you use controlled substances?	YES	NO
34.	Have you EVER taken Bis-phosphonates? Zometa, Aredia, Fosamax	YES	NO
35.	Have you EVER taken fen-phen, redux or other weight loss products?	YES	NO
36.	Women: Are you pregnant or suspect you might be? Are you nursing? Are you taking contraceptives or other hormones?	YES YES	NO NO
37.	Do you have any disease, condition, or problem not listed?	YES	NO
38.	Is there anything else we should know about your health?	YES	NO
39.	Would you like to speak with the Doctor privately about any problem?	YES	NO

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S/GUARDIAN'S SIGNATURE _____ DATE_____

DENTIST'S SIGNATURE _____ DATE _____

Patient's Name_____

Medical History Update #1

Date _____

Please review your medical history.

☐ There are no changes to my medical history ☐ There are changes to my medical history described below

_____

_____

_____

Patient's Signature_____ Doctor's Signature_____

Medical History Update #2

Date _____

Please review your medical history.

☐ There are no changes to my medical history ☐ There are changes to my medical history described below

_____

_____

_____

Patient's Signature_____ Doctor's Signature_____

Medical History Update #3

Date _____

Please review your medical history.

☐ There are no changes to my medical history ☐ There are changes to my medical history described below

_____

_____

_____

Patient's Signature_____ Doctor's Signature_____

Medical History Update #4

Date _____

Please review your medical history.

☐ There are no changes to my medical history ☐ There are changes to my medical history described below

_____

_____

_____

Patient's Signature_____ Doctor's Signature_____

Medical History Update #5

Date _____

Please review your medical history.

☐ There are no changes to my medical history ☐ There are changes to my medical history described below

_____

_____

_____

Patient's Signature_____ Doctor's Signature_____