Medical History - Current Copy

Patient Name: Birth Date: Date Created:

General

Who is your primary care physician? ◯ Yes ◯ No If yes

How would you rate your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

What are your preferred pronouns? ◯ Yes ◯ No If yes

Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? ◯ Yes ◯ No If yes

Are you on a special diet? ◯ Yes ◯ No If yes

Do you use any controlled substances? ◯ Yes ◯ No If yes

Do you use tobacco or nicotine? ◯ Yes ◯ No If yes

Do you smoke or vape? ◯ Yes ◯ No

Women: Are you...

Pregnant/Trying to get pregnant? ◯ Yes ◯ No If yes

Nursing? ◯ Yes ◯ No

Taking oral contraceptives? ◯ Yes ◯ No

Allergies

Are you allergic to any of the following?

☐ Aspirin	☐ Chlorhexidine (CHX)
☐ Codeine	☐ Erythromycin
☐ Fluoride	☐ Fruit
☐ Iodine	☐ Latex
☐ Local Anesthetics	☐ Metals
☐ Milk	☐ Nuts
☐ Red Dye	☐ Sulfa
☐ Tetracyclin	

Other ☐ If yes

Please list any medications or vitamins you are taking, with dosages.

Medical History

Do you currently have, or ever had?

AIDS/HIV Positive	◯ Yes ◯ No	ADD/ADHD	◯ Yes ◯ No	Anemia	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Arthritis or Gout	◯ Yes ◯ No	Blood Disorder/Disease	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Chemotherapy	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No
Digestive or Eating Disorders	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No
Glaucoma	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No
Heart Problems or Cardiac Stent	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No	High or Low Blood Pressure	◯ Yes ◯ No
Infective Endocarditis	◯ Yes ◯ No	Kidney Disease	◯ Yes ◯ No	Liver Disease or Jaundice	◯ Yes ◯ No
Neurologic Disorders	◯ Yes ◯ No	Orthoedic or Soft Tissue Implant	◯ Yes ◯ No	Osteoporosis/Osteopenia	◯ Yes ◯ No
Psychiatric Treatment	◯ Yes ◯ No	Radiation Treatment	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Scarlet Fever	◯ Yes ◯ No	Seizures or Epilepsy	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Sleep Disorders	◯ Yes ◯ No	STI/STD/HPV	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Tonsillitis	◯ Yes ◯ No	Trouble Hearing/Hearing Aid	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Ulcers	◯ Yes ◯ No	Viral Infections	◯ Yes ◯ No		

Any additional Comments?

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (o

Signature of Patient, Parent or Guardian:

X Date:_____