MEDICAL HISTORY

Welcome! *So that we may provide you with the best possible care, please complete both sides of this medical and dental history form. All information is completely confidential.*

PATIENT'S NAME: _____

Have you been under the care of a medical doctor during the past two years? ..... Yes No
If yes, for what? _____
Physician's Name _____ Telephone _____
Address _____ City _____ State _____ Zip _____

Are you currently taking any medications, drugs or pills? ..... Yes No
If yes, please list name and dosage: _____
_____

Have you ever had an allergic or adverse reaction to any medication or substance (including foods)? ..... Yes No
If yes, please list: _____

Circle Yes or No to indicate whether or not you have had or now have the following conditions or treatments:

Heart Condition ..... Yes / No	Contact Lenses ..... Yes / No	Cortisone Medicine ..... Yes / No
Heart Attack ..... Yes / No	Glaucoma ..... Yes / No	Arthritis/Rheumatism ..... Yes / No
Heart Surgery ..... Yes / No	Bruise Easily ..... Yes / No	Fen-Phen or Redox..... Yes / No
Chest Pain (Angina) ..... Yes / No	Emphysema ..... Yes / No	Special or Restricted Diet ..... Yes / No
Congenital Heart Disease ..... Yes / No	Chronic Cough ..... Yes / No	Latex Sensitivity ..... Yes / No
Stroke ..... Yes / No	Tuberculosis (T.B.) ..... Yes / No	Cancer ..... Yes / No
High Blood Pressure ..... Yes / No	Asthma ..... Yes / No	Tumors ..... Yes / No
Mitral Valve Prolapse ..... Yes / No	Hay Fever ..... Yes / No	Chemotherapy ..... Yes / No
Artificial Heart Valve ..... Yes / No	Sinus Trouble ..... Yes / No	Radiation Therapy ..... Yes / No
Rheumatic Fever ..... Yes / No	Allergies or Hives ..... Yes / No	Neurological Disorders ..... Yes / No
Heart Murmur ..... Yes / No	Liver Disease ..... Yes / No	Nervous/Anxious ..... Yes / No
Heart Pacemaker ..... Yes / No	Hepatitis Type ____ ..... Yes / No	Epilepsy or Seizures ..... Yes / No
Anemia ..... Yes / No	Yellow Jaundice ..... Yes / No	Fainting or Dizzy Spells ..... Yes / No
Hemophilia ..... Yes / No	AIDS ..... Yes / No	Psychiatric/Psychological Care .. Yes / No
Ulcers ..... Yes / No	HIV Positive ..... Yes / No	Kidney Trouble ..... Yes / No
Alcoholism ..... Yes / No	Venereal Disease ..... Yes / No	Artificial Joints or Heart Valves... Yes / No
Drug Addiction ..... Yes / No	Cold Sores/Fever Blisters ..... Yes / No	Sickle Cell Disease ..... Yes / No
Diabetes ..... Yes / No	Blood Transfusion ..... Yes / No	Osteoporosis..... Yes / No
Family History of Diabetes ..... Yes / No	Thyroid Problems ..... Yes / No	Bone Disease or Bone Cancer... Yes / No
	Swollen Ankles ..... Yes / No	

Do you have or have you had any disease, condition or problem not listed ..... Yes No
If yes, please list: _____

Have you ever had prolonged or unusual bleeding? ..... Yes No

Are you taking or have you ever taken any of the following medications: Aredia (pamidronate), Zometa (zolendronic acid), Bonefos (clodronate), Actonel (risedronate), Boniva (ibandronate), Fosamax (alendronate), Skelid (tiludronate), Didronel (etidronate)..... Yes No

Have you ever had a reaction to a local anesthetic? ..... Yes No

Do you use more than two pillows to sleep? ..... Yes No

Do you experience frequent thirst, frequent eating or frequent urination? ..... Yes No

Women: Are you pregnant?... Yes No If yes, due date: _____ Nursing?... Yes No Taking birth control pills?... Yes No

(Please complete the other side)