PATIENT MEDICAL HISTORY	Y	N
Are you now under the care of a physician? If, Yes: Physician Name: ___________________ Phone:___________	❐	❐
Are you in good health? If no, explain___________________	❐	❐
Has there been any change in your general health within the past year? If yes, what condition is being treated?	❐	❐
Have you had a serious illness, operation or been hospitalized in the past 5 years? If yes, what was the illness or problem? ___________________	❐	❐
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	❐	❐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? If yes, explain _________ ___________________	❐	❐
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax® , Actonel® , Atelvia, Boniva® , Reclast, Prolia) for osteoporosis or Paget's disease? If yes, what medication ___________________	❐	❐
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia® , Zometa® , XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Date Treatment began: ___________________	❐	❐

Please mark all that apply below

High blood pressure ❐	**Angina** ❐	**Kidney Diseases** ❐	**Hay Fever / Allergies** ❐
Heart Attack ❐	**Stroke** ❐	**AIDS or HIV infection** ❐	**Tuberculosis** ❐
Rheumatic Fever ❐	**Anemia** ❐	**Sexually Transmitted Disease** ❐	**Radiation Therapy** ❐
Swollen Ankles ❐	**Emphysema** ❐	**Thyroid Problem** ❐	**Glaucoma** ❐
Fainting / Seizures ❐	**Cancer** ❐	**Heart Disease** ❐	**Recent Weight Loss** ❐
Asthma ❐	**Arthritis** ❐	**Cardiac Pacemaker** ❐	**Liver Disease** ❐
Low Blood Pressure ❐	**Hepatitis / Jaundice** ❐	**Heart Murmur** ❐	**Respiratory Problems** ❐
Epilepsy / Convulsions ❐	**Stomach Troubles/ Ulcers** ❐	**Heart Trouble** ❐	**Anemia** ❐
Leukemia ❐	**Chest Pains** ❐	**Mitral Valve Prolapse** ❐	**Eating Disorder** ❐
Diabetes ❐	**Easily Winded** ❐	**Frequently Tired** ❐	**Other** ❐

Do you have any disease, condition, or problem not listed above that you think I should know about?
If yes, explain ______________________________

____

Do you wear contact lenses? Yes ❒ No ❒

Do you use controlled substances (drugs)? Yes ❒ No ❒
If yes, explain______________________________

Do you use tobacco?
Yes ❒ **What kind?**______________ **No** ❒

Are you taking or have you recently taken any prescription or over the counter medicine(s)? If yes, please list ______________

____

____

Medications list continued:
____
____
____
____
____

Mark all that apply below

Women Only

Taking birth control **Yes** ❒ **No** ❒

Taking hormone medication **Yes** ❒ **No** ❒

Pregnant **Yes**❒ **No** ❒

# of Months ____________ **Weeks** ________________

Nursing **Yes** ❒ **No** ❒

Allergy to any of the following (mark all that apply)

Local anesthetics ❒
Aspirin ❒
Penicillin or other antibiotics ❒
Barbiturates ❒
sedatives ❒
Sulfa drugs ❒
Codeine or other narcotics ❒
Metals ❒
Latex (rubber) ❒
Iodine ❒
Food ❒
Other ____________________ ❒

Dental History

Date of your last dental exam ____________ Date of last dental x-rays____________	Y	N
Do your gums bleed while brushing or flossing?	❒	❒
Do you have any clicking, popping or discomfort in the jaw?	❒	❒
Do you brux or grind your teeth?	❒	❒
Do you have sores or ulcers in your mouth?	❒	❒
Do you wear dentures or partials?	❒	❒
Have you ever had a serious injury to your head or mouth?	❒	❒
Do you have any teeth sensitive to sweet or sour liquids/foods?	❒	❒
Do you feel pain in any of your teeth?	❒	❒
Do you have dental anxiety? If yes, is it ❒ Mild ❒ Moderate ❒ Severe	❒	❒

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian ______________________________ **Date** ______________

Signature of Dentist ______________________________ **Date**______________