

MEDICAL HISTORY

CIRCLE ONE

The following medical information is for our records and will be confidential.

- 1. Do you consider yourself to be in good general health? yes / no
- 2. The approximate date of your last physical exam: _____
- 3. If you are under active care by a physician, please state the purpose or condition: _____

- 4. Please list each serious illness you may have had, or may have: _____

- 5. Please list surgical operations you have had: _____
- 6. Please list all medication(s) you take on a regular basis, or have taken on a regular basis for 30 days including aspirin: _____
- 7. Have you taken prescribed or unprescribed narcotics or drugs in the last 30 days? yes / no
- 8. Have you, or are you, being treated with oral (I.E. Fosamax) or IV Bisphosphonate drugs for Osteoporosis or Bone Cancer? If yes, please explain: _____ yes / no
- 9. Do you routinely take antibiotics before dental treatment? yes / no
- 10. Do you take "blood thinners" or anticoagulants? yes / no
- 11. Do you take medicine for Asthma? yes / no
- 12. Do you take insulin? yes / no
- 13. Do you smoke or use other tobacco? yes / no
- 14. Do you have allergies? yes / no
Penicillin ___ Novacaine ___ Codeine ___ Latex ___ Other ? _____

15. Have you had any of the following? (Please check the appropriate responses)

YES	NO		YES	NO	
___	___	high / low blood pressure	___	___	tuberculosis
___	___	liver disease	___	___	neurological problems
___	___	heart disease	___	___	joint replacement
___	___	lung disease	___	___	arthritis / painful swollen joints
___	___	thyroid problems	___	___	ulcer disease / hyperacidity
___	___	seizure disorder	___	___	radiation therapy
___	___	asthma	___	___	anemia
___	___	cancer	___	___	anxiety problems / depression
___	___	diabetes	___	___	chemical dependency
___	___	hepatitis	___	___	sinus problems
___	___	rheumatic fever	___	___	fainting spells
___	___	heart rhythm problems	___	___	general anesthesia
___	___	heart murmur	___	___	prolonged bleeding
___	___	heart valve problems	___	___	communicable disease
___	___	blood transfusion	___	___	immune system failure

16. Have you had problems with any previous medical or dental treatment(s) or is there any other information about your health that you feel that we should know? yes / no
If yes, please explain: _____

17. Do you wear contact lenses? yes / no

18. If appropriate: Are you pregnant? - or is there a possibility that you may be pregnant at the present time? yes / no
If yes, how far along (months) _____
Are you nursing? yes / no

19. Are you wearing removable dental appliances? yes / no

20. Please state the reason / problem that brought you to this office (as you understand it) _____

I attest and certify that the above answers are true and complete.

Signature _____ Date _____ (12/06B)