# Medical History

Patient Name _____

1. Physicians Name _____ Phone number _____
2. Are you aware of having an allergy or adverse reaction to any substance or medication? If so, please list

   _____

3. Are you currently taking aspirin or any blood thinner? Please circle, Y/N
4. Are you currently taking any medication? If so, please list

   _____

5. Have you ever taken any bone loss (osteoporosis) medications such as Fosamax, Actonel, Boniva, Zoledronate or any similar drugs? Please circle Y / N
6. Have you ever had a history of radiation to the head, neck, jaw region? Please circle Y/N
7. Indicate which of the following you have had by circling Y (yes) or N (no) to each item:
   a. Bleeding disorders (Y/N)
   b. Heart surgery, disease, heart attack (Y/N)
   c. Congenital heart disease (Y/N)
   d. High/Low blood pressure (Y/N)
   e. Artificial heart valve/pacemaker (Y/N)
   f. Mitral valve prolapse (Y/N)
   g. Stroke (Y/N)
   h. Artificial joints (hip/knee) (Y/N)
   i. Diabetes (Y/N)
   j. Asthma (Y/N)
   k. Thyroid problems (Y/N)
   l. Kidney disease (Y/N)
   m. Glaucoma (Y/N)
   n. Tuberculosis (Y/N)
   o. Latex sensitivity (Y/N)
   p. Tumors (Y/N)
   q. Chemotherapy and/or radiation (Y/N)
   r. Hepatitis A, B, C (Y/N)
   s. HIV/AIDS (Y/N)
   t. Neurological disorders (Y/N)
   u. Epilepsy or seizures (Y/N)
   v. Psychiatric care (Y/N)
8. Do you have any disease, condition, or problem not listed? If so, please list

   _____

9. Women: Are you pregnant or think you could be pregnant? Y/N. Are you nursing? Y/N
10. Women: If you are taking birth control of any type and are prescribed antibiotic, antibiotics have been shown to reduce efficacy of birth control, please be aware.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all of the questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Please sign: _____ Date: _____