Patient Medical History

Patient Name_________________________________ Today's date: ______________________________

Your Physician:_________________________________ Office Name/ Phone:______________________________________

Date of last medical exam:_________________________________

Are you under medical treatment now? ☐ YES ☐ NO If yes:____________________________________

Have you ever been hospitalized or had a major operation? ☐ YES ☐ NO If yes:_______________________________

Have you ever had a serious head or neck injury? ☐ YES ☐ NO If yes:_________________________________

Are you taking any medication(s) including non-prescription medicine? ☐ YES ☐ NO

If yes, please list:____

Have you ever taken medication containing Bisphosphonates for osteoporosis? Examples: Fosamax, Boniva, Actonel, Reclast, Aclasta. ☐ YES ☐ NO If yes: ____

Do you use tobacco? ☐ YES ☐ NO

Women: Are you: ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives/Birth Control?

ALLERGIES: Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

☐ Other allergies: If yes, list: ____

Do you use controlled substances? ☐ YES ☐ NO If yes: ____

Check the box if you have, or ever had any of the following medical conditions:

AIDS/HIV positive □	Cortisone Medicine □	Hemophilia □	Radiation Treatment □
Alzheimer's □	Diabetes □ type:______	Hepatitis A □	Recent Weight Loss □
Anemia □	Drug Addiction □	Hepatitis B or C □	Renal Dialysis □
Angina □	Easily Winded □	Herpes □	Rheumatic Fever □
Arthritis/Gout □	Epilepsy/Seizures □	High Cholesterol □	Scarlet Fever □
Artificial Heart Valve □	Excessive Bleeding □	High Blood Pressure □	Shingles □
Artificial Joint □	Excessive Thirst □	Hives or Rash □	Sickle Cell Disease □
Asthma □	Fainting/Dizziness □	Hypoglycemia □	Sinus trouble □
Blood Disease □	Frequent Cough □	Irregular Heartbeat □	Spina Bifida □
Blood Transfusion □	Frequent Diarrhea□	Kidney Problems □	Stomach/Bowel Disease □
Breathing Problems □	Frequent Headaches □	Leukemia □	Stroke □
Bruise Easily □	Genital Herpes □	Liver Disease □	Swelling of Limbs □
Cancer □	Glaucoma □	Lung Disease □	Thyroid Disease □
Chemotherapy □	Hay Fever □	Mitral Valve Prolapse □	Tonsillitis □
Chest Pains □	Heart Attack/Failure □	Osteoporosis □	Tuberculosis □
Cold Sores □	Heart Murmur □	Pain in Jaw Joints □	Tumors or Growths □
Congenital Heart Defect □	Heart Pacemaker □	Parathyroid Disease □	Ulcers □
Convulsions □	Heart Disease □	Psychiatric Care □	Yellow Jaundice □

Other Serious Illness not listed: ____

To the best of my knowledge, the questions on this form have been accurately answered.

Signature of Patient, Parent or Guardian: Date: