Medical History

Name _____
First MI Last
Physicians Name _____ Telephone _____
Date of last physical _____
General Health: Excellent Good Fair

Answers to the following are for our records and are confidential.

Are you under current medical treatment? Yes No
If yes, please explain: _____
Are you currently taking any medications or herbal supplements? Yes No
Medications (prescription and non-prescription) vitamins, supplements: _____
_____
_____
Do you have allergies or adverse reaction to drugs? Yes No
If yes, please list drug and reaction: _____
Have you ever taken I.V. or oral Bisphosphonates for bone density such as Fosamax, Actonel, Boniva, Aredia, Zometa or Bonefos? Yes No
Are you on a special diet? Yes No
Have you lost or gained more than 10 pounds in the past year? Yes No
Do you use any form of tobacco? Yes No
What type? Cigarettes Cigars Snuff Chew How much? _____
Are you interested in quitting? Yes No
Do you consume alcohol? Yes No If yes, how much per week on average _____
Women, are you: Pregnant Nursing On hormone therapy On birth control medication
Trying to get pregnant? Yes No

Do you have or have you ever had any of the following?

Rheumatic Fever	Yes No	**Diabetes/FAMILY HISTORY** ...	Yes No
Respiratory Disease	Yes No	**High Blood Pressure/FAMILY HISTORY**	Yes No
Heart Murmur	Yes No	**Stroke/FAMILY HISTORY**.....	Yes No
Heart Disease/FAMILY HISTORY	Yes No	Epilepsy.....	Yes No
Other Heart Ailment	Yes No	Head Injuries.....	Yes No
Chemo/Radiation Therapy	Yes No	Caffeine Dependency.....	Yes No
Mitral Valve Prolapse	Yes No	Psychological/Psychiatric Treatment	Yes No
Cancer	Yes No	Bleeding Problems	Yes No
Artificial Joints	Yes No	Blood Transfusion	Yes No
Liver Disease	Yes No	Latex Sensitivity	Yes No
HIV or AIDS	Yes No	Organ Transplant	Yes No
Kidney Disease/FAMILY HISTORY	Yes No	**Venereal Disease INCLUDES HPV+**	Yes No
Arthritis/FAMILY HISTORY.....	Yes No	Hepatitis	Yes No
Major Operations	Yes No	Pacemaker	Yes No
Have you ever been told you need Antibiotics prior to treatment.....	Yes No	**Dementia/Alzheimer's/FAMILY HISTORY**	Yes No
		Gum Disease/FAMILY HISTORY.....	Yes No

Do you have a disease or condition not listed Yes No
If yes, please list: _____

***There is a significant link between gum disease and systemic health, so family history is important!*

Initial Signature (Parent's if minor) _____ Date _____

Medical History Updates:
Signature (Parent's if minor) _____ Date _____

Signature (Parent's if minor) _____ Date _____