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?

Condition			Condition		
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			**Dementia/Alzheimer's/FAMILY HISTORY**	Yes	No
Antibiotics prior to treatment ...	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 ______________