

**MEDICAL HISTORY (2/24/22)(Copy)**

Patient Name:

Birth Date:

Date Created:

Are you under a physician's care now?  Yes  No If yes

Have you ever been hospitalized or had a major operation?  Yes  No If yes

Are you taking any medications, pills, or drugs?  Yes  No If yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Yes  No If yes

Do you smoke, vape or use tobacco?  Yes  No

Do you use controlled substances?  Yes  No If yes

Women: Are you...

Pregnant/Trying to get pregnant?  Nursing?

Are you allergic to any of the following?

Aspirin  Penicillin  Codeine  Acrylic

Metal  Latex  Sulfa Drugs  Local Anesthetics

Other?  If yes

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

AIDS / HIV + <input type="radio"/> Yes <input type="radio"/> No	Radiation / Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Alzheimer's / Dementia <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No
Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A B or C <input type="radio"/> Yes <input type="radio"/> No	Rheumatic / Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No	Emphysema / COPD <input type="radio"/> Yes <input type="radio"/> No
High / Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Arthritis / RA <input type="radio"/> Yes <input type="radio"/> No	Epilepsy / Seizures <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No
Artificial Joint / Valve <input type="radio"/> Yes <input type="radio"/> No	Blood Thinners (currently) <input type="radio"/> Yes <input type="radio"/> No	Asthma <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No
Autism <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No	Cancer / Leukemia <input type="radio"/> Yes <input type="radio"/> No
Thyroid / Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Heart Attack <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No
Cold Sores / Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No
Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble / Disease <input type="radio"/> Yes <input type="radio"/> No		

Have you ever had any serious illness not listed above?  Yes  No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X \_\_\_\_\_

Date: \_\_\_\_\_