MEDICAL HISTORY

Do you have a personal physician? ………………………………………………………….. ☐ Yes ☐ No
Physician's Name: ____
Physician's Phone: ____
Date of last visit: ____
How would you describe your present health? (Please check one)
☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Don't Know
Have you been hospitalized in the past two years? ………………………………………........... ☐ Yes ☐ No
Do you take any medications? (Including aspirin) …………………………………….. ☐ Yes ☐ No
If yes, list here____
____
Do you currently take any biophosonates? (Fosamax, Boniva, Actonel, etc.) …………………… ☐ Yes ☐ No
Are you allergic to penicillin or any other medicines or drugs? .... ☐ Yes ☐ No
If so, list ____
Are you allergic to latex/rubber? ……………………………………………………………….. ☐ Yes ☐ No
Have you ever had an adverse reaction to a local anesthetic (Novocaine) or pain medication? … ☐ Yes ☐ No
If so, list____
Does ibuprophen (Advil) irritate your stomach? ………………………………………………… ☐ Yes ☐ No
Have you ever had excessive bleeding that required special treatment? ………………………… ☐ Yes ☐ No
Have you been diagnosed with immunodeficiency, HIV, AIDS? …………………………….. ☐ Yes ☐ No
Do you smoke or use smokeless tobacco? …………………………………………………… ☐ Yes ☐ No
Do you have a history of substance abuse? ………………………………………………….. ☐ Yes ☐ No
Have you been directed by a physician to take antibiotics prior to having your teeth cleaned? ….. ☐ Yes ☐ No
Check any of the following which you may have had:

☐ Heart Trouble	☐ High Blood Pressure	☐ Persistent Cough
☐ Heart Surgery	☐ Low Blood Pressure	☐ Tuberculosis
☐ Heart Valve Prosthesis	☐ Diabetes	☐ Asthma
☐ Congenital Heart Defects	☐ Hepatitis or Jaundice	☐ Epilepsy/Seizures
☐ Infective Endocarditis	☐ Ulcers	☐ Stroke
☐ Cardiac Pacemaker	☐ Kidney Disease	☐ Arthritis
☐ Lung Disease	☐ Cancer	☐ Joint Replacement Prosthesis

Women Only:
Are you pregnant? ☐ Yes ☐ No
Are you nursing? ☐ Yes ☐ No
Are you taking oral contraceptives? ☐ Yes ☐ No

Do you have any disease, condition or problem not listed above that you feel we should know about? If yes please explain: ____

I certify that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical history.

X____
Signature of Patient (or Parent/Guardian, if minor) **Date**