Medical History For:_____ Date: _____

Patient's Date of Birth: _____ Home # : _____ Cell #: _____

Emergency Contact**:**_____ Phone #:_____

Dental History

Previous Dentist:_____ Phone#:_____
Date of last exam:_____date of last cleaning :_____Were X-rays taken:_____
History of gum surgery?_____
Have you had any complication with previous dental treatment? □**Yes** □ **No**

Medical History

Name of Primary Care Physician: _____ Phone #:_____
Have you been under the care of a physician in the last 2 years? □**Yes** □ **No**
If yes, please explain:_____
Are you currently taking any **medications**? □**Yes** □ **No**
If yes, list: _____, _____, _____, _____,
_____, _____, _____, _____,

Have you been hospitalized or had surgeries in the last 5 years? □**Yes** □ **No**

If yes, please explain:_____

Have you had an **ALLERGIC** reaction to any medications or local anesthetic? □**Yes** □ **No**

If yes, please explain:_____

Are you allergic to or had a bad reaction to latex or any metals: □**Yes** □ **No**

If yes, please explain:_____

Are you taking or have taken **Bisphosphonate** drugs (oral or IV) to treat bone loss such as Actonel, Boniva, Fosamax,

Zometa? □**Yes** □ **No** If yes, How long?_____

Do you smoke: □**Yes** □ **No** Packs per day:_____ # of years_____ Do you Chew: □**Yes** □ **No**

Do you use alcohol: □**Yes** □ **No** How often?_____

Please check any of the following conditions you may have had, or have at the present:

□ Heart Attack
□ Heart Surgery
□ Heart Disease
□ Chest pain
□ Congenital heart disease
□ **Heart Murmur**-yr_____
□ High/Low Blood pressure
□ Artificial **Valve Replacement**-yr____
□ Rheumatic Fever
□ Stroke
□ Ulcer or stomach trouble
□ Diabetes
□ Radiation or Chemo therapy
□ Anemia
□ Hearing problem
□ Sinus trouble
□ Arthritis
□ Sleep Apnea
□ Emphysema
□ Respiratory Problems(Asthma)
□ Tuberculosis
□ **Hepatitis**_____type
□ Blood Thinners
□ HIV/AIDS
□ Psychiatric Care
□ Neurological disorders
□ Epilepsy or seizures
□ Fainting or Dizzy spells
□ shortness of breath
□ Kidney Disease
□ **Artificial** joints-yr_____
□ Cancer/Tumor
□ Blood Transfusion
□ Alcohol or chemical dependency
□ Venereal disease

*For women only, are you pregnant? □ **Yes** □ **No** Taking birth control? □ **Yes** □ **No**

Of the best of my knowledge, the foregoing questions have been accurately answered. If I ever have any changes in health, or if my medication changes, I will inform the dentist at the next appointment.

Patient or **Legal Guardian**_____ **Date**_____