Patient Medical History

	YES	NO
1. Have you been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain: _____	☐	☐
2. Please list any medications you are currently taking: _____		
3. Have you ever taken Fosamax, Boniva, Aceronel, or any cancer medications containing bisphonphonates?	☐	☐
4. Do you use tobacco?	☐	☐
5. Do you use controlled substances?	☐	☐
6. Do you take blood thinners?	☐	☐

7. Are you allergic to or have you had reactions to the following?	YES	NO
Local Anesthetics (e.g. Novocain)……	☐	☐
Latex Rubber……	☐	☐
Penicillin, Tetracyclines or any other Antibiotics…..	☐	☐
Other Allergies: _____ **(please list)** _____		

8. **Women Only:**		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

FOR ALL ROUTINE DENTAL CARE: Have you ever been instructed by a physician to premedicate? Yes or No
If yes, regimen: _____

Check if you have or have had any of the following:

___ Joint Replacement- Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement
If yes- Date: _____

___ Artificial Valve (stents or conduits)
___ Mitral Valve Prolapse
___ History of Ineffective Endocarditis
___ Heart Murmur
___ Serious congenital Heart Conditions
___ Heart Trouble/Chest Pains
___ Heart Disease
___ Heart Attack
___ Cardiac Pacemaker

___ Asthma
___ Respiratory Problems
___ Epilepsy/Convulsions
___ Fainting/Seizures
___ Emphysema
___ Tuberculosis
AIDS or HIV Infection
___ Hepatitis/Jaundice
___ Sexually Transmitted Disease
___ High Blood Pressure
___ Low Blood Pressure

___ Kidney Diseases
___ Diabetes
___ Thyroid Problem
___ Stroke
___ Stomach Troubles/Ulcers
___ Angina
___ Leukemia
___ Cancer
___ Radiation Therapy
___ Liver Disease

If you have any medical condition not listed above, please describe: _____

_____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I will not hold my dentist or his staff responsible for any action they take or do not take because of errors or omissions that I may have made in completion of this form.

X _____

Signature of Patient (or parent/guardian if patient is a minor) ***Date***