ALERT:	

MEDICAL HISTORY FORM

Date of Birth: Sex: M / F Height: Weight: For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be kept confidential. 1. Are you in good health? Yes No 2. Has there been any change in your health in the past year? Yes No 3. My last physical exam was on / / /	Name:		e:	Date:			
1. Are you in good health? Yes No 2. Has there been any change in your health in the past year? Yes No 3. My last physical exam was on// 4. Are you now under the care of a physician? Yes No if so, for what condition? Yes No if so, for yellow it is not taking or have you ever taken Bisphosphonates for osteoporosis or chemotherapy for multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia or Zometa)? Yes No if so, please list: Yes Yes No if so, please list: Yes No	Da	ite c	of Birth: Sex: M / F	Height:	Weight: _		
2. Has there been any change in your health in the past year?				ver applies.	Your answers	are for	our
If so, for what condition? 5. The name and address of my physician is: 6. Have you had any serious illness, operation or hospitalization within the past 5 years? 7. Have you had an artificial joint replacement (knee, hip, shoulder, etc.)? 8. Are you taking or have you ever taken Bisphosphonates for osteoporosis or chemotherapy for multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia or Zometa)? 8. Are you taking any medicine(s) including diet pills, non-prescription, vitamins, homeopathic or natural remedies? 9. Are you taking any medicine(s) including diet pills, non-prescription, vitamins, homeopathic or natural remedies? 10. Do you have or have you had any of the following diseases or problems? 11. Do you have or have you had any of the following diseases or problems? 12. Damaged heart valves, artificial valves or heart murmur. 13. Damaged heart valves, artificial valves or heart murmur. 14. Ves No 15. Rheumatic Heart Disease. 16. Have you taking or have you had any of the following diseases or problems? 17. Lohest pain upon exertion? 18. No 19. Alerational problems are trained exercise? 19. No 10. Chest pain upon exertion? 19. No 10. Chest pain upon exertion? 19. No 10. Lohest pain upon exertion? 19. No 10. Allergies. 19. No 10. Allergies. 19. No 10. Allergies. 19. No 10. Asthma or hay fever. 19. No 10. Fainting spells or seizures 19. No 10. Diabetes. 10. Persinten or recurring mouth sores 19. No 19. Respiratory problems, emphysema, bronchitis, etc. 19. No 20. Stomach ulcer or hyperacidity 20. No 21. Respiratory problems, emphysema, bronchitis, etc. 21. Persistent cough or cough that produces blood 22. Persistent swollen neck glands. 23. No 24. No 24. No 25. No 26. No 27. Persistent swollen neck glands. 28. No 29. No 29. No 29. No 20. Low blood pressure 20. No 21. Chasters. 20. No 20.	2.	На	as there been any change in your health in the past yea	ar?		Yes	
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or any other heart condition						Yes	No
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t. Low blood pressure							
u. Epilepsy or neurological disorder							
v. CancerYes No							
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	abnormal bleeding?			No	
a. Have you ever required a blood transfusion?					
12. Do you have any blood disorder such as anemia?					
	had treatment for a tumor or growth?			No	
14. Have you had radiation therapy to the head, neck or jaws?					
	to or have you had a reaction to:				
	netics			No	
	antibiotics			No	
•				No	
	or sleeping pills			No	
•				No	
	atta an arang atta a			No	
•	other narcotics			No	
	ber products			No	
	and a suit of the			No	
_	any serious trouble associated with previo		. Yes	No	
	ny other condition or disease you think the		. Yes	No	
If so, explain:	or chew Tobacco?		Voc	No	
How much?	JI CITEW TODACCO:		. 163	NO	
	st history of alcohol or chemical depender	— ncv or emotional disorder			
	the care we provide you?		. Yes	No	
	g contact lenses?			No	
	g removable dental appliances?			No	
	talk with the doctor privately about anythi			No	
Women					
23. Are you pregnant or trying to become pregnant?				No	
24. Do you have problems associated with your menstrual period?				No	
25. Are you nursing?				No	
26. Are you taking birth control pills?				No	
Chief Dental Com	nlaint.				
Chief Dental Com	plaint:				
	derstand the above. Any questions I had newers. I understand it is my respor				
Date:	Patient's Signature:				
Medical History Up	date:				
Date	Medical Changes	Signature			