ALEX E. IVANOFF, DDS

Patient Medical History

Patient Name: _____ Date: _____ /_____ / _____

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

If yes, please explain: : _____

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

If yes, please explain: : _____

Have you ever had a serious head or neck injury? **Yes** **No**

If yes, please explain: : _____

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

Please list: _____

_____

Do you take, or have you taken, Phen-Fen or Redux? **Yes** **No**

If yes, please explain: : _____

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

If yes, please explain: : _____

Are you on a special diet? **Yes** **No**

Do you use tobacco? **Yes** **No**

Are you allergic to any of the following?

Aspirin **Penicillin** **Codeine** **Acrylic** **Metal**

Latex **Sulfa Drugs** **Local Anesthetics**

Other: _____

_____

Do you use controlled substances? **Yes** **No**

If yes, please explain: : _____

<u>For Women: Are you ...</u>

Pregnant/Trying to get pregnant? **Nursing?** **Taking Oral Contraceptives?**

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

AIDS/HIV Positive Test	Yes	No	Cortisone Medication	Yes	No
Hepatitis A	Yes	No	Hepatitis B or C	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No
Anemia	Yes	No	Rheumatic Fever	Yes	No
Emphysema	Yes	No	High Blood Pressure	Yes	No
Epilepsy or Seizures	Yes	No	Scarlet Fever	Yes	No
Hives or Rash	Yes	No	Artificial Heart Valve	Yes	No
Artificial Joint	Yes	No	Sickle Cell Disease	Yes	No
Irregular Heartbeat	Yes	No	Sinus Trouble	Yes	No
Blood Disease	Yes	No	Kidney Problems	Yes	No
Blood Transfusion	Yes	No	Frequent Headaches	Yes	No
Breathing Problems	Yes	No	Low Blood Pressure	Yes	No
Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Radiation Treatments	Yes	No	Recent Weight Loss	Yes	No
Bruise Easily	Yes	No	Excessive Bleeding	Yes	No
Lung Disease	Yes	No	Thyroid Disease	Yes	No
Renal Dialysis	Yes	No	Arthritis/Gout	Yes	No
Convulsions	Yes	No	Tuberculosis	Yes	No
Ulcers	Yes	No	Cancer	Yes	No
Angina	Yes	No	Stroke	Yes	No
Leukemia	Yes	No	Asthma	Yes	No
Shingles	Yes	No	Hypoglycemia	Yes	No
Rheumatism	Yes	No	Herpes	Yes	No
Diabetes	Yes	No	Alzheimer's Disease	Yes	No
Hemophilia	Yes	No	Chemotherapy	Yes	No
Excessive Thirst	Yes	No	Fainting Spells/Dizziness	Yes	No
Chest Pains	Yes	No	Heart Murmur	Yes	No
Frequent Cough	Yes	No	Stomach/Intestinal Disease	Yes	No
Heart Pacemaker	Yes	No	Heart Attack/Failure	Yes	No
Osteoporosis	Yes	No	Mitral Valve Prolapse	Yes	No
Tumors or Growths	Yes	No	Pain in Jaw Joints	Yes	No
Psychiatric Care	Yes	No	Congenital Heart Disorder	Yes	No
Heart Trouble/Disease	Yes	No			

Have you ever had a serious illness not listed? Yes No

If yes, please explain: : _____

Comments: _____

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

_____ _____

Patient/Legal Guardian Signature **Date**