Medical History

Name_____**Birthdate**_____

Primary Care Physician_____**Telephone**_____

Address_____ **Date of last physical**_____

Do you require antibiotics prior or dental treatment? ____ Yes ____ No

Have you had an adverse reaction to penicillin, aspirin, codeine, local anesthetics, latex, metals, or any other medication?

____ Yes ____ No Please list

_____

Are you taking or have you taken Bisphosphonates such as Fosamax, Actonel, Boniva, Zometa or Aredia? ___ Yes ___ No

***Do you presently have OR have a history of:**

___ Alcoholism
___ Allergies (seasonal)
___ Alzheimer's, dementia, memory loss
___ Angina Pectoris (chest pain)
___ Arthritis
___ Artificial heart valve
___ Artificial joints (i.e. hip, knee)
___ Asthma / Breathing problems
___ Back problems
___ Blood transfusion
___ Cancer
___ Chemotherapy or radiation
___ Cortisone or steroid therapy
___ Depression
___ Dental anxiety
___ Diabetes (type 1 or type 2)
___ Drug addiction
___ Epilepsy or seizures
___ Excessive bleeding
___ Fainting or dizzy spells
___ Glaucoma
___ Headaches
___ Heart murmur
___ Heart problem or recent heart surgery
___ Hepatitis
___ High / Low blood pressure
___ High cholesterol
___ HIV positive / AIDS
___ Immune deficiency
___ Kidney disease
___ Liver disease
___ Lung disease
___ Mitral valve prolapse
___ Mouth sores or growths
___ Pacemaker
___ Parkinson's disease
___ Psychiatric care
___ Respiratory disease
___ Rheumatic fever
___ Sinus problems
___ Skin rash
___ Snoring/Sleep disorder
___ Stomach problems (i.e. acid reflux)
___ Stroke
___ Teeth grinding or clenching
___ Thyroid disease
___ TMJ pain (pain in jaw)
___ Tobacco use (i.e. smoke or smokeless)
___ Tonsillitis
___ Tuberculosis
___ Venereal disease
___ Other

Office Use Only

(Women) Could you be pregnant? ___ Yes ___ No, Breastfeeding? ___ Yes ___ No, Are you taking birth control? ___ Yes ___ No

Signature _____ **Date** _____

Patient Name _____

Current Medications

Medication Name	Dose/Frequency	Reason for taking

Medical History Update

Date	Change in medical history or medication	Patient Initial	Provider Initial