Medical History

Physician's Name ______________________ Date of Last Visit ______________

Have you ever used a Bisphosphonate medication for osteoporosis? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva, Zometa, Aredia, Nerixia, Actasta. ❒ Yes ❒ No

Do you require pre-medication antibiotic for dental appointments? ❒ Yes ❒ No

Do you regularly take dietary supplements or herbal medicines? ❒ Yes ❒ No

If Yes, do you take any of the following: ❒ Diet or Energy Supplements ❒ Echinacea ❒ Garlic ❒ Ginger ❒ Ginkgo ❒ Ginseng ❒ Kava ❒ St. Johns Wort ❒ Valerian ❒ Vitamin E ❒ Fish Oil

Have you recently substituted herbs for presription or over-the-counter drugs? ❒ Yes ❒ No

Have you had any serious illness or operations? ❒ Yes ❒ No If yes, please describe: ______________

____

FOR WOMEN ONLY: Are you pregnant? ❒ Yes ❒ No Are you nursing? ❒ Yes ❒ No

Are you taking birth control pills? ❒ Yes ❒ No

CHECK (✔) IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

❒ ADD/ADHD
❒ Anemia
❒ Arthritis, Rheumatism
❒ Artificial Heart Valves
❒ Artificial Joints (Knee, Hip)
❒ Asthma
❒ Autism
❒ Back Problems
❒ Blood Disease
❒ Cancer
❒ Chemical Dependency
❒ Chemotherapy
❒ Circulatory Problems
❒ Cold Sores
❒ Cortisone Treatments
❒ Cough, Persistent
❒ Cough up Blood
❒ Diabetes
❒ Epilepsy
❒ Fainting
❒ Glaucoma
❒ Headaches
❒ Heart Murmur
❒ Heart Problems
❒ Hemophilia
❒ Hepatitis
❒ High Blood Pressure
❒ HIV / AIDS
❒ Jaw Pain
❒ Kidney Disease
❒ Liver Disease
❒ Mitral Valve Prolapse
❒ Osteoporosis
❒ Pacemaker
❒ Radiation Treatment
❒ Respiratory Disease
❒ Rheumatic Fever
❒ Scarlet Fever
❒ Shortness of Breath
❒ Skin Rash
❒ Sleep Apnea
❒ Stroke
❒ Swelling of Feet or Ankles
❒ Thyroid Problems
❒ Tobacco Habit
How long? __________
❒ Tonsillitis
❒ Tuberculosis
❒ Ulcer

Medications

List of medications you are currently taking: Reason for taking:

____
____
____
____
____
____
____

Allergies

❒ Asprin ❒ Codeine ❒ Latex ❒ Local Anesthetic ❒ Metals ❒ Penicillin ❒ Sulfa

❒ Others Please List: ______________________________

Signature

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or ommissions that I may have made in the completion of this form.

Date: ______________ Signature: ______________________________