

MEDICAL HEALTH HISTORY

NAME _____ DOB _____

ADDRESS _____

EMAIL _____

HOME # _____ CELL # _____

DENTAL INSURANCE: YES NO IF YES, PLEASE PROVIDE: _____

MEDICAL HISTORY

Have you been hospitalized for any surgical operations or serious illness in the past year?

If yes, please explain: _____

Are you currently taking any medication[s] including non-prescription medicine?

If yes, please explain: _____

Do you have any health problems from the last year that need further clarification? YES NO

If yes, please explain: _____

Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? YES NO

Do you use controlled substances? YES NO

Do you smoke/chew tobacco? YES NO

ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTION TO THE FOLLOWING?

Local Anesthetics YES NO Penicillin/Tetracycline/or any other antibiotic[s] YES NO

Sulfa Drugs YES NO Codeine YES NO

Sedatives YES NO Iodine YES NO

Aspirin YES NO Metal YES NO

Latex YES NO Other [please specify] _____

MEDICAL CONDITIONS [Please circle the ones that apply to you]:

Allergies [Seasonal/Pollen/Dust]

Excessive Bleeding

Kidney / Liver Disease

Anemia

Excessive Thirst

Leukemia

Angina / Chest Pain

Fainting / Seizures

Mitral Valve Prolapse

Arthritis / Gout

Glaucoma

Nursing

Artificial Joint

Heart Attack / Failure

Pregnant / Trying to Get Pregnant

Asthma

Heart Disease

Taking Oral Contraceptives

Cancer

Heart Pacemaker

Rheumatic Fever

Chemotherapy / Radiation

Heart Murmur

Sudden Weight Loss / Gain

Diabetes

Hepatitis A B C

Swelling of Limbs

Drug Addiction

Herpes

Thyroid Conditions _____

Emphysema

High / Low Blood Pressure

Tuberculosis _____

Epilepsy / Convulsions

HIV / AIDS / HPV

Other _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I have any change in my health, I will inform the Doctor at the next appointment without fail.

Signature _____

Date _____

Emergency Contact _____

Relationship _____

Phone # _____

Doctor / Hygienist Signature _____

Date _____