Medical History

Patient Name: _____ Initial Date: _____

Update: _____

Update: _____

Update: _____

Update: _____

Update: _____

Health Information

Personal Physician Name: _____

Physician's Address: _____ Phone No. _____

Yes	No	
☐	☐	Have you ever had problems with prior dental treatment?
☐	☐	Do you or have you used any tobacco products?
☐	☐	Have you been hospitalized within the past 2 years? For what? _____
☐	☐	Are you currently being treated by a physician? For what? _____
☐	☐	Have you ever received counseling for excessive use of alcohol and/or prescription drugs?
☐	☐	Are you allergic to any drugs? What? _____
☐	☐	Have you ever had a skin rash or other reactions to metal jewelry?
☐	☐	Do you bleed excessively upon injury?
☐	☐	Are you pregnant?
☐	☐	Have you taken Fosamax, Actonel, Aredia, Boniva or any bone replacement therapy drug?
☐	☐	Are you currently taking any medicines or drugs? What?_____

_____

Please list any other allergies _____

Circle Any of the Following Conditions Which Applies

- Acid Reflux/Vomiting
- Aids/HIV
- Anemia
- Asthma
- Cancer/Treatment
- Chest Pain/Angina
- Diabetes
- Dry Mouth
- Epilepsy/Seizures
- Glaucoma
- Headaches/Jaw Pain
- Heart Problem
- Hepatitis/Liver Disease
- High Blood Pressure
- Jaundice
- Kidney Problems
- Low Blood Pressure
- Psychological Therapy
- Stroke
- Tuberculosis/Emphysema
- Other Diseases

I have read and comply with the Notice of Privacy Practices

Signature: _____ Date: _____