BRECKENRIDGE DENTAL GROUP

MEDICAL HISTORY

Patient's Name _____

Last First Middle Initial Date of Birth

PLEASE CIRCLE THE APPROPRIATE ANSWER.
IF YOU DO NOT KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

				Comments / Medications
1.	Physician's Name _____			
2.	Are you under a physician's care for any reason at this time?..... Since when _____ Why _____	Yes	No	
3.	When was your last complete physical exam? _____			
4.	Are you taking any medication or substances?..... (If yes, please list in comments/medications section)	Yes	No	
5.	Do you routinely take vitamins, herbal supplements, natural products?.....	Yes	No	
6.	Are you allergic to any medications or substances? (please list)……	Yes	No	
7.	Do you have any other allergies or hives?.....	Yes	No	
8.	Do you have any problems with penicillin, antibiotics, anesthetics or other medications?.....	Yes	No	
9.	Are you sensitive to any metals or latex?.....	Yes	No	
10.	Are you pregnant or suspect you may be?.....	Yes	No	
11.	Do you use any birth control medications?.....	Yes	No	
12.	Have you ever been treated for or been told you might have heart disease?.....	Yes	No	
13.	Do you have a pacemaker, an artificial heart valve implant, or been diagnosed with mitral valve prolapse?.....	Yes	No	
14.	Have you ever had rheumatic fever?.....	Yes	No	
15.	Are you aware of any heart murmurs?.....	Yes	No	
16.	Do you have high or low blood pressure? (please circle)……	Yes	No	
17.	Have you ever had a serious illness or major surgery?..... If so, explain _____	Yes	No	
18.	Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition?.....	Yes	No	
19.	Have you ever taken Fosamax, Zometa, Aredia or any other oral or intravenous treatment (bisphosphonates) for bone tumors, excessive calcium in you blood, or osteoporosis?.....	Yes	No	
20.	Do you have inflammatory diseases, such as arthritis or rheumatism?.....	Yes	No	
21.	Do you have any artificial joints/prosthesis?.....	Yes	No	
22.	Do you have any blood disorders, such as anemia, leukemia, etc?.....	Yes	No	
23.	Have you ever bled excessively after being cut or injured?.....	Yes	No	
24.	Do you have any stomach problems?.....	Yes	No	
25.	Do you have any kidney problems?.....	Yes	No	
26.	Do you have any liver problems?.....	Yes	No	
27.	Are you diabetic?.....	Yes	No	
28.	Do you have fainting or dizzy spells?.....	Yes	No	
29.	Do you have asthma?.....	Yes	No	
30.	Do you have epilepsy or seizure disorders?.....	Yes	No	
31.	Do you or have you had venereal or any sexually transmitted disease?.....	Yes	No	
32.	Have you tested HIV positive?.....	Yes	No	
33.	Do you have AIDS?.....	Yes	No	
34.	Have you had or do you test positive for hepatitis?.....	Yes	No	
35.	Do you or have you had T.B.?.....	Yes	No	
36.	Do you smoke, chew, use snuff or any other forms of tobacco?.....	Yes	No	
37.	Do you regularly consume more than one or two alcoholic beverages a day?...	Yes	No	
38.	Do you habitually use controlled substances?.....	Yes	No	
39.	Have you had psychiatric treatment?.....	Yes	No	
40.	Have you taken any prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products?.....	Yes	No	
41.	Do you have any disease, condition, or problem not listed?..... If so, explain _____	Yes	No	
42.	Is there anything else we should know about your health that we have not covered in this form?.....	Yes	No	
43.	Would you like to speak to the Doctor privately about any problem?.....	Yes	No	

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

MEDICAL HISTORY