**MEDICAL HISTORY:**

**Name:**_____**Medical Alert**:_____

Physicians name:_____Phone:_____

Are you taking any medication, drugs, or herbal remedies, including aspirin? Name, Dosage, & Reason:

_____

_____

_____

Have you had medical care/ Hospitalization within the past two years? Yes No

Describe:_____

Are you aware of any Allergic or Adverse reactions to any substance or medications? Yes No

Describe:_____

Any bone loss prevention drugs such as, Fosamax, Boniva, or bisphoshonnates? Yes No

Are you possibly pregnant or breast feeding at this time? Yes No

**Indicate any of the following you have had or have:**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Heart-Surgery, Disease,Attack | Yes | No | Ulcers | Yes | No | Hepatitis A, B, C | Yes | No |
| Need to PreMed | Yes | No | Diabetes | Yes | No | Mitral Valve Prolapse | Yes | No |
| Congenital Heart Disease | Yes | No | Thyroid Problem | Yes | No | VD/AIDS/HIV Positive | Yes | No |
| Heart Murmur | Yes | No | Glaucoma | Yes | No | Cold Sores/Blisters | Yes | No |
| High/low blood pressure | Yes | No | Emphysema | Yes | No | Hemophilia | Yes | No |
| Heart Valve/Pacemaker | Yes | No | Tuberculosis | Yes | No | Sickle Cell Disease | Yes | No |
| Rheumatic Fever | Yes | No | Asthma | Yes | No | Bruise Easily | Yes | No |
| Arthritis/Rheumatism | Yes | No | Hay Fever/Allergies | Yes | No | Neurological Disorder | Yes | No |
| Cortisone Medicine | Yes | No | Latex Sensitivity | Yes | No | Epilepsy/Seizures | Yes | No |
| Stroke | Yes | No | Sinus Trouble | Yes | No | Fainting/Dizzy Spells | Yes | No |
| Kidney Trouble | Yes | No | Radiation/Chemo | Yes | No | Nervous/Anxious | Yes | No |
| Artificial Joints (Hip, Knee,) | Yes | No | Tumors | Yes | No | Psychiatric Care | Yes | No |
| Oral Surgery | Yes | No | Periodontal issues | Yes | No | Orthodontic Treatment | Yes | No |
| TMJ (Jaw) Issues | Yes | No | Smoker | Yes | No | Cancer | Yes | No |

Any Disease, Condition, or Problem not listed? Describe:_____

_____

Do you have any dental problems now? Describe:_____

Are you seen by a alternating dental office? Describe:_____

I understand the information is necessary to provide me with dental care in a safe and efficient manner and I consent to that treatment. Should further information be needed, you have my permission to ask the health care provider, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature_____Date_____

Dentist Signature_____Date_____