



MEDICAL HISTORY

NAME _____ DATE OF BIRTH _____

PHYSICIAN'S NAME _____ ADDRESS _____

CURRENT MEDICATIONS _____

HOSPITALIZATIONS/SURGERY IN PAST 5 YEARS _____

ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT? _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING: PLEASE CIRCLE ALL THAT APPLY AND EXPLAIN

HEART DISEASE	HIGH BLOOD PRESSURE	ASTHMA OR ALLERGIES	HIV
CONGENITAL HEART DEFECT	DIABETES	SINUS PROBLEMS	CANCER
MITRAL VALVE PROLAPSE	KIDNEY DISEASE	EYE OR EAR PROBLEMS	STROKE
RHEUMATIC FEVER	LIVER DISEASE	ULCER	HEPATITIS B
HEART MURMUR	TUBERCULOSIS	JOINT REPLACEMENT	HEPATITIS C
ANGINA	LUNG DISEASE	SEIZURE DISORDER	

EXPLAIN: _____

DO YOU TAKE BLOOD THINNERS? _____

HAVE YOU TAKEN A PRESCRIBED APPETITE SUPPRESSANT IN THE LAST 5 YEARS (E.G., FEN-PHEN, IONIMIN, ADIPEX, FASTIN, PONDIMIN, OR REDUX)? _____

ARE YOU CURRENTLY TAKING OR HAVE TAKEN ANY OF THE BONE DENSITY MEDICATIONS (ACTONEL, FOSAMAX, OR BONIVA)? _____

MEDICATION ALLERGIES: PLEASE CIRCLE ALL THAT APPLY

PENICILLIN _____ CODEINE _____ ERYTHROMYCIN _____ ASPIRIN _____
OTHER (PLEASE LIST) _____

DENTAL HISTORY

DATE OF LAST VISIT TO A DENTIST _____

DENTIST'S NAME _____

ADDRESS _____ PHONE# _____

ANY PROBLEMS RELATED TO PREVIOUS DENTAL TREATMENT? _____

PURPOSE OF TODAY'S VISIT? _____

DO YOU REQUIRE ANTIBIOTIC PRE-MEDICATION FOR DENTAL VISITS? (Y/N)

WHY? _____

DO YOU SMOKE? _____

DO YOU FAINT EASILY? _____

SIGNATURE _____ DATE _____