YOUR MEDICAL HISTORY

Date: _____

Patient's Name: _____

Your Physician's Name: _____

Have you had any recent surgeries?	Yes	No
Have you had any orthopedic surgeries?	Yes	No
Are you currently under a physician's care?	Yes	No
Are you currently taking any medications or substances?	Yes	No

If so, please list: _____

Medicine & reason _____

_____

Are you allergic to any medications or substances?	Yes	No

If so, please list: _____

Do you have any other allergies?	Yes	No
Are you pregnant or suspect you might be?	Yes	No
Do you use any birth control medications?	Yes	No

Do you currently have or have you ever had any of the following?

High blood pressure	Yes	No	Heart Murmurs	Yes	No
Rheumatic fever	Yes	No	Pacemaker	Yes	No
Artificial valves	Yes	No	Artificial joints	Yes	No
Radiation treatment	Yes	No	Chemotherapy	Yes	No
Arthritis/rheumatism	Yes	No	Anemia	Yes	No
Leukemia	Yes	No	Hemophilia	Yes	No
Diabetes	Yes	No	Asthma	Yes	No
Epilepsy	Yes	No	Other seizures	Yes	No
Venereal disease	Yes	No	HIV positive	Yes	No
AIDS	Yes	No	Hepatitis A - B -C	Yes	No
Tuberculosis	Yes	No	Alcoholism	Yes	No
Metal allergies	Yes	No	Latex allergy	Yes	No
Mitral Valve Prolapse	Yes	No	Drug Addictions	Yes	No

Do you take or have you ever taken any of the following medications:

Acton el (Risedronate) Aredia (Pamidronate) Didronel (Etidronate) Reclast (Zoledronate)
Fosamax (Alendronate) Skelid (Tiludronate) Zometa (Zoledronate)

_____

Would you like to speak to the Dentist privately about any problem?	Yes	No

Please inform our office of any changes in your medical history.

I certify that the above information is complete and accurate.

Patient's/Guardian's Signature _____

MEDICAL HISTORY