

# MEDICAL HISTORY

<b>Patient Name</b> _____	<b>Health Alert</b> _____	<b>BP:</b> _____
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1. Have you been under the care of a medical doctor during the past 2 years? . . . . . Yes No  
 If yes, for what? \_\_\_\_\_  
 Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_
2. Have you taken any medication/drugs during the past 2 years? . . . . . Yes No
3. Are you taking any medication, drugs, or pills now? . . . . . Yes No  
 If yes, please list name and dosage: \_\_\_\_\_
4. Are you aware of having an allergic (or adverse reaction) to any medication or substance?  
 If yes, please list: \_\_\_\_\_ . Yes No
5. Have you ever taken Bisphosphonates? (Fosamax, Aredia, Bonafos, Zometa). . . . . Yes No
6. Have you been a patient in the hospital during the past 5 years? . . . . . Yes No

7. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

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|---------------------------------------|--|---|
| Tuberculosis.....Yes No               | Cortisone Medicine.....Yes No            | Hepatitis A (infect.) B(serum) C.Yes No |
| Asthma.....Yes No                     | Swollen Ankles.....Yes No                | Venereal Disease.....Yes No             |
| Hay Fever.....Yes No                  | Stroke.....Yes No                        | A.I.D.S.....Yes No                      |
| Latex Sensitivity .....Yes No         | Diet (Special Restricted).....Yes No     | HIV Positive.....Yes No                 |
| Allergies/Hives .....Yes No           | Artificial Joints (hip, knee).....Yes No | Prostate Cancer.....Yes No              |
| Sinus Trouble .....Yes No             | Kidney Trouble.....Yes No                | Blood Transfusion.....Yes No            |
| Heart(Surgery/Disease/Attack)..Yes No | Thyroid Problems.....Yes No              | Hemophilia.....Yes No                   |
| Chest Pain.....Yes No                 | Ulcers.....Yes No                        | Sickle Cell Disease.....Yes No          |
| Congenital Heart Disease.....Yes No   | Diabetes.....Yes No                      | Bruise Easily.....Yes No                |
| Heart Murmur.....Yes No               | Glaucoma.....Yes No                      | Liver Disease.....Yes No                |
| High Blood Pressure.....Yes No        | Contact Lenses.....Yes No                | Yellow Jaundice.....Yes No              |
| Mitral Valve Prolapse.....Yes No      | Emphysema.....Yes No                     | Neurological Disorders.....Yes No       |
| Artificial Heart Valve.....Yes No     | Chronic Cough.....Yes No                 | Epilepsy or Seizures .....Yes No        |
| Heart Pacemaker.....Yes No            | Radiation Therapy.....Yes No             | Fainting or Dizzy Spells.....Yes No     |
| Rheumatic Fever.....Yes No            | Chemotherapy.....Yes No                  | Breast Cancer.....Yes No                |
| Arthritis/Rheumatism .....Yes No      | Tumors.....Yes No                        | Psychiatric (Psychological Care)Yes No  |

7. Do you use more than two pillows to sleep? . . . . . Yes No
8. Do you have or have you had any disease condition, or problem not listed above? Yes No  
 If yes, please list: \_\_\_\_\_
9. **Women** Are you: Pregnant? Yes, \_\_\_\_\_Months No **Nursing** Yes No  
 Taking birth control pills? Yes No

I understand the above information is necessary to provide me with dental care in a safe & efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1 1/2% finance charge will be added to any balance over 30 days In the event of default I (we) promise to pay legal interest on the indebtedness, together with such collection costs & reasonable attorney fees as may be required to effect collection of this note

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

History Review	
Doctor Signature	Date