PATIENT MEDICAL HISTORY

Patient Name_______________________________ Date of Birth_____________________ □Male □Female

Medical History: Check the box **ONLY** if you have now, or have had in the past:

CARDIOVASCULAR (heart)
□High blood pressure □
□Irregular heart beat,□ pacemaker□
□Chest pain □ □Heart attack □
□Mitral Valve Prolapse □
□Heart murmur □
□Heart surgery: bypass, transplant□

PULMONARY (lungs)
□Asthma □
□Emphysema, bronchitis □
□Pneumonia □
□Tuberculosis □
□PPD+ □

DERMATOLOGY (skin) □rash/hives/sores

NERVOUS SYSTEM
□Alzheimer's □ □Anxiety □
□Depression □ □Seizure □
□Headaches □ □Stroke □
□Parkinsons, MS, Cerebral Palsy □
□Muscular dystrophy □

GASTROINTESTINAL (digestive)
□Hepatitis □ □Anorexia □
□Cirrhosis □ □ Bulimia □
□Ulcer □
□Transplant: liver; kidney □
□Heart burn (reflux) □

□**SURGERY:**________________________________
____

□Hospitalization: recent/past
Are you under a physician's care? □yes□no
Physician's name:___________________________
Do you have any other health problems not listed that we should know about? □yes□no
Explain_____________________________________

GENITOURINARY (kidney, urinary)
□Dialysis □ □Syphilis □□Gonorrhea □□Herpes□

ENDOCRINE
□Diabetes □ □Thyroid □
□ Prostate □ □Hypothyroid disorder□□Prosthetic heart valve □

MUSCULOSKELETAL
□Artificial joints □ Arthritis Degenerative/Rheumatoid□ Osteoporosis□

IMMUNE SYSTEM: Are you allergic to or have had a reaction to:
Penicillin or other antibiotics□ Sulfa drugs□ Aspirin□ Codeine□ Latex□
Local anesthetics / novocaine□ any metals□ Barbiturates / sedatives or sleeping pills□
Other____
Do you have or have ever had the following: □Lupus □HIV □Sjogren's syndrome

HEMATOLOGIC (blood)
□Anemia□ Bleeding disorder□ □Bruise easily□
□Hemophilia□ □Blood transfusion□ □Leukemia / blood cancer□
□Sickle cell anemia□ HIV□

Have you ever had abnormal bleeding or any complications after dental procedure or surgery? □yes □no Explain:____
____

CANCER: □ any history of cancer

DRUG USE : Do you use?
□Alcohol □□Tobacco□
□Prior or current injection drug use□
□Prior or current non-injection recreational drug use□

WOMEN: □I am pregnant or possibly pregnant □ I am nursing □ Post-menopause □ Oral contraceptive

Are you taking or have ever taken the following oral or intravenous <u>BISPHOSPHONATES</u> medications which are associated with Osteoporosis and Cancer Treatment:
<u>ORAL:</u> □Fosamax □Actonel □Boniva □Didronel □Skelid □Other____________
<u>INTRAVENOUS</u>: □Zometa□□Aredia□□Didronel □Bonefos □Other____________

DO YOU TAKE PRESCRIPTION DRUGS?

□ NO
□ YES (**LIST BELOW**)
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____
____
____
____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. If I ever have any changes in my health, I will inform the doctor.
Signature/Date____

Has there been any changes in your health since last visit? Y N
Explain____
____
Signature/Date______________________________________

Has there been any changes in your health since last visit? Y N
Explain____
____
Signature/Date____