PATIENT NAME: _____ **BIRTHDATE**_____

Medical History Form

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? .....**YES __ NO__**
If **YES** please explain:_____
_____

Have you ever been hospitalized or had a major operation?.....**YES__ NO__**
If **YES** please explain:_____
_____

Do you take any supplements?.....**YES __ NO __**
If **YES** please list:_____
_____

Are you taking and/or using any medication, pills, or drugs?.....**YES __ NO __**
If **YES** please list:_____
_____

Do you require pre-medication (antibiotics)
prior to your dental appointment?.....**YES __ NO __**
If **YES** please explain:_____
_____

Have you ever taken Fosamax, Boniva, Actonel, or any
other medications for Osteoporosis?.....**YES __ NO __**
If **YES** please list:_____

Are you taking any blood thinners? If yes, which one?.....**YES __ NO __**
If **YES** please list:_____

Do you take Rx Fluoride?.....**YES __ NO __**

Do you use tobacco?.....**YES __ NO __**

Who is your Medical Doctor/Clinic _____

WOMEN: Please select any of the following that apply.

___Pregnant/Trying to get pregnant?.....**___Nursing?**.....**___Taking Oral Contraceptives?**

EVERYONE: Are you allergic to any of the following?

__ Aspirin..... **__ Penicillin**..... **__ Codeine**..... **__ Acrylic**

__ Metals..... **__ Latex**.....**__ Sulfa Drugs**.....**__ Local Anesthetics**

__ OTHER.....If **OTHER** please list:_____

Please **CIRCLE** if you have, or you had, any of the following?

AIDS/HIV Positive	Cortisone Medicine	Hemophilia	Radiation Treatments
Alzheimer's Disease	Diabetes	Hepatitis A	Recent Weight Loss
Anaphylaxis	Drug Addiction	Renal Dialysis	Anemia
Herpes	Angina	High Blood Pressure	Arthritis/Gout
Epilepsy or Seizures	High Cholesterol	Artificial Heart Valve	Excessive Bleeding
Hives or Rash	Shingles	Artificial Joint	Excessive Thirst
Hypoglycemia	Sickle Cell Disease	Asthma	Fainting Spells/Dizziness
Irregular Heartbeat	Blood Disease	Frequent Cough	Kidney Problems
Blood Transfusions	Leukemia	Stomach/Intestinal Disease	Breathing Problems
Frequent Headaches	Liver Disease	Stroke	Bruise Easily
Low Blood Pressure	Swelling of Limbs	Cancer	Lung Disease
Thyroid Disease	Chemotherapy	Mitral Valve Prolapse	Chest Pains
Heart Attack/Failure	Tuberculosis	Cold Sores/Fever Blisters	Heart Murmur
Pain in Jaw Joints	Tumors or Growths	Congenital Heart Disease	Heart Pacemaker
Convulsions	Heart Trouble/Disease	Psychiatric Care	

Have you had any other serious illness not listed above?.....**YES __ NO __**
If **YES** please explain:_____

Do you have **Sleep Apnea**?.....**YES __ NO __**
If **YES** do you use a **CPAP machine**?.....**YES __ NO __**