Patient Name:

Medical History

Are you currently taking any medications on a daily basis? Yes No

If yes please list:_____

Have you ever taken bone loss prevention medications? (Fosamax, Actonel, Boniva, etc.) Yes No

Have you ever had an allergic or adverse reaction to any medication? Yes No

If yes please specify:_____

Please circle if you have had, or have at present:

heart (surgery/disease/attack)	chest pain	congenital heart disease
high/low blood pressure	heart murmur	mitral valve prolapse
pacemaker	rheumatic fever	arthritis
cortisone medicine	stroke	diabetes
thyroid problems	glaucoma	contact lenses
emphysema	asthma	sinus trouble
radiation therapy	chemotherapy	tumors
hepatitis A/B/C	venereal disease	A.I.D.S/H.I.V.
hemophilia	bruise easily	liver disease
neurological disorders	epilepsy/seizures	general anxiety
psychiatric care	joint replacements	

Do you have or have you had any disease, condition, or problem not listed? Yes No

If yes please elaborate:_____

Women:

Are you pregnant? Or think you could be? Yes No

Do you take birth control pills? Yes No

I understand the above information is necessary to provide me with dental care in a safe and 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 healthcare provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature:_____Date:_____