Patient Name

MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years? ❑ yes ❑ no
   If yes, for what_____
   Physician's Name_____Phone_____
   Address_____ City_____ State_____ Zip_____
2. Have you taken any medication or drugs during the past two years? ❑ yes ❑ no
3. Are you taking any medication, drugs or pills now? ❑ yes ❑ no
   If yes, please list name, dosage & what medication is for_____
   _____
4. Are you aware of having an allergic (or adverse) reaction to any medications or substance? ❑ yes ❑ no
   If yes, please list:_____
5. Have you been a patient in the hospital during the past five years? ❑ yes ❑ no
6. Indicate which of the following you have had, or have at present. Please check "yes" or "no" to each item.

A.I.D.S.	❑ yes ❑ no	Emphysema	❑ yes ❑ no	Neurological Disorders	❑ yes ❑ no
Allergies or Hives	❑ yes ❑ no	Epilepsy or Seizures	❑ yes ❑ no	Premedication	❑ yes ❑ no
Arthritis/Rheumatism	❑ yes ❑ no	Fainting or Dizzy Spells	❑ yes ❑ no	Psychiatric/Psychological Care	❑ yes ❑ no
Artificial Heart Valve	❑ yes ❑ no	Glaucoma	❑ yes ❑ no	Radiation Therapy	❑ yes ❑ no
Artificial Joints(hip, knee, etc.)	❑ yes ❑ no	H.I.V. Positive	❑ yes ❑ no	Rheumatic Fever	❑ yes ❑ no
Asthma	❑ yes ❑ no	Hay Fever	❑ yes ❑ no	Sickle Cell Disease	❑ yes ❑ no
Blood Transfusion	❑ yes ❑ no	Heart (Surgery, Disease, Attack)	❑ yes ❑ no	Sinus Trouble	❑ yes ❑ no
Bruise Easily	❑ yes ❑ no	Heart Murmur	❑ yes ❑ no	Stroke	❑ yes ❑ no
Chemotherapy	❑ yes ❑ no	Heart Pacemaker	❑ yes ❑ no	Swollen Ankles	❑ yes ❑ no
Chest Pain	❑ yes ❑ no	Hemophilia	❑ yes ❑ no	Thyroid Problems	❑ yes ❑ no
Chronic Cough	❑ yes ❑ no	Hepatitis A (infectious) B (serum)	❑ yes ❑ no	Tuberculosis	❑ yes ❑ no
Cold Sores/Fever Blisters	❑ yes ❑ no	High Blood Pressure	❑ yes ❑ no	Tumors	❑ yes ❑ no
Congenital Heart Disease	❑ yes ❑ no	Kidney Trouble	❑ yes ❑ no	Ulcers	❑ yes ❑ no
Contact Lenses	❑ yes ❑ no	Latex Sensitivity	❑ yes ❑ no	Venereal Disease	❑ yes ❑ no
Cortisone Medication	❑ yes ❑ no	Liver Disease	❑ yes ❑ no	Yellow Jaundice	❑ yes ❑ no
Diabetes	❑ yes ❑ no	Mital Valve Prolapse	❑ yes ❑ no		
Diet(Special/Restricted)	❑ yes ❑ no	Nervous/Anxious	❑ yes ❑ no		

7. Are you taking or have you ever taken biophosphonates (Actonel , Fosamax, Boniva)? ❑ yes ❑ no
8. Do you have or have you had disease, condition, or problem not listed? ❑ 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 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 health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

Patient Signature _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, (print name) _____, have been made aware of this office's Notice of Privacy Practices.

_____ Signature

_____ Date