

MEDICAL HISTORY

Please complete the following questions so that we may thoroughly diagnose your condition. The information you provide is for our records and will be considered strictly confidential. In addition, it is your responsibility to update this medical history when any changes occur.

1. Are you currently under your medical doctor's care for a current medical problem? **Yes** **No**
Reason: _____
2. Have you been hospitalized in the past five years? **Yes** **No**
Reason: _____
3. Are you required to take premeds prior to dental treatment? **Yes** **No**
4. Have you received therapy for alcoholism or drug addiction during the past five years? **Yes** **No**
5. Have you ever had any **ALLERGIC or ADVERSE REACTIONS** to anesthetics, antibiotics, or other medications? Please explain: _____ **Yes** **No**
6. Have you ever had an **ALLERGIC or ADVERSE REACTION to LATEX**? **Yes** **No**
7. Have you ever required a blood transfusion? **Yes** **No**
Please explain: _____
8. Have you ever had surgery and/or radiation for a tumor, growth or other condition? **Yes** **No**
9. Do you use tobacco (smoking, snuff, chew)?..... **Yes** **No**
10. Are you taking or scheduled to begin taking either of the medications?
Alendroate (Fosamax®) or Risedronate (Actonel®) for osteoporosis or Paget's disease? **Yes** **No**
11. List any medications you are currently taking:

12. **Do you or have you ever had any of the following (please check):**

- | | |
|---------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> Active tuberculosis | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Angina pectoris | <input type="checkbox"/> Joint replacement |
| | ANY complications: _____ |
| <input type="checkbox"/> Artificial heart valves | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Sickle cell disease | <input type="checkbox"/> Lung disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart murmur of prolapsed valve MVP |
| <input type="checkbox"/> Abnormal bleeding | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Cancer/chemotherapy | <input type="checkbox"/> Psychiatric problems |
| <input type="checkbox"/> Congenital heart defects | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Difficult breathing | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Fever blisters | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Venereal diseases |
| <input type="checkbox"/> Hepatitis | |

Women Only - Are you: Pregnant? **Yes** **No** If yes, number of weeks? _____
Taking birth control pills or hormonal replacement? **Yes** **No**
Nursing? **Yes** **No**

ALL THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

Signature of Patient/Legal Guardian: _____ **Date:** _____

HIPAA ACKNOWLEDGEMENT AND RECEIPT OF NOTICE

PRINT NAME: _____ **SIGNATURE:** _____ **DATE:** _____

**YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT.

PATIENT REFUSED TO SIGN HIPAA _____