Medical History

PATIENTS NAME _____ DATE OF BIRTH_____ Today's Date_____

List all medications, herbal remedies, and over the counter medications that you are taking:	List all substances you are allergic to:

Do you now have, OR have you ever had any of the following? Circle "Y" for Yes and "N" for No

AIDS	Y / N	Epilepsy/Seizures	Y / N	Joint Replacement	Y / N
Anemia	Y / N	Fen-Fen Redux	Y / N	Kidney Disease	Y / N
Anxiety Disorder	Y / N	Gastro-esophageal reflux disease	Y / N	Liver Disease	Y / N
Arthritis	Y / N	Glaucoma	Y / N	Psychiatric treatment	Y / N
Artificial heart valves	Y / N	Heart murmur	Y / N	Pacemaker	Y / N
Asthma	Y / N	Heart surgery	Y / N	Sensitivity to latex	Y / N
Bisphosphonates (Fosamax)	Y / N	Heart trouble	Y / N	Sensitivity to metals	Y / N
Osteoporosis treatment	Y / N	Hepatitis type_____	Y / N	Sexually transmitted diseases	Y / N
Cancer or tumor	Y / N	High Blood Pressure	Y / N	Sinus trouble	Y / N
Diabetes	Y / N	HIV Positive	Y / N	Stroke	Y / N
				Tuberculosis	Y / N

1. Have you been treated by a physician or hospitalized in the past year? ---------- Yes No
   IF YES, Explain: _____
2. Has there been any change in your general health in the past year? ---------- Yes No
   IF Yes, What? _____
3. Have you had any unusual reaction to "novocaine" or local anesthetic? ---------- Yes No
4. Have you ever had problems with prolonged bleeding from a cut, injury, or tooth extraction? Yes No
5. Are you in a substance abuse recovery program? ---------- Yes No
6. Have you ever used or are you currently using any narcotic or recreational drugs?---------- Yes No
7. Do you smoke or use tobacco? ---------- Yes No
   If Yes, How often per day? _____Years?_____ would you like to stop? ----- Yes No
8. Is there anything related to your medical history that you have not indicated? ---------- Yes No
   IF Yes, Explain _____

Women Only

9. Are you pregnant or possibly pregnant? ---------- Yes No
   If pregnant, When are you due?_____
10. Are you taking birth control or other hormones? ---------- Yes No

Patient or Guardian Signature _____ **Date** _____

Providers Comments:

Doctors Signature _____ Date_____

Alerts: Antibiotic Premed Allergies Hepatitis Heart Condition Medication Anesthetic Other