Medical History

NAME_____

Name of Physician _____ City_____

Yes No Are you in good health?

Yes No Have you been treated by a physician for any condition within the last year?
If so, please explain._____

Yes No Are you taking any anti-coagulant (blood thinner) drug?

Yes No Has a dentist or physician recommended antibiotics prior to dental treatment?

Yes No Do you use mood altering or addictive drugs?

Yes No Have you ever taken medications for osteoporosis? This includes Fosamax, Actonel, Didronel, Boniva, Aredia, Zometa, Prolia, Reclast

Please List Current Medications including prescription drugs, herbal supplements, vitamins and over-the-counter medications_____

_____

Do you have or have you had any of the following diseases or problems?

___Alcohol sensitivity	___Alcoholism	___Allergy - Latex	___Allergy - Other
___Allergy – Penicillin	___Anemia	___Arthritis	___Artificial Joints
___Asthma	___Bisphosphonates	___Blood Thinners	___Cancer
___Chemotherapy	___Corticosteroids	___Crohn's Disease	___Diabetes
___Eating Disorder	___Emphysema	___Epilepsy	___Excessive Bleeding
___Fainting/Dizziness	___Gastric Reflux	___Glaucoma	___Head Injury
___Heart Disease	___Heart Murmur	___Heart Valve Problems	___Hemophilia
___Hepatitis	___High Blood Pressure	___HIV	___HPV
___Jaundice	___Kidney Disease	___Liver Disease	___Mood Altering Drugs
___Nervous Disorders	___Osteoporosis	___Other	___Pacemaker
___Psychiatric Care	___Radiation Treatment	___Rheumatic Fever	___Sinus Problems
___Sleep Apnea	___Snoring	___Stomach Problems	___Stroke
___Thyroid Condition	___Tobacco Use	___Tuberculosis	___Ulcers
___Venereal Disease			

If needed, explain _____

_____

Do you have any medical problems not listed above?_____
Women: If you are pregnant at this time, your due date: _____

I concur that the above medical history is correct and complete.
Patient/Parent Signature _____