Patient Name:

MEDICAL HISTORY

Medical Alert:

1. Physician's Name #1 ______________ Phone (   ) ______________
   Physician's Name # 2 ______________ Phone (   ) ______________
2. Have you had any medical care within the past two years?........ Yes No
   Date of last heath care exam or physical: __________ What was this exam for? __________
3. Are you currently being treated for any medical conditions? .... Yes No
   Please list ______________
4. Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of asprin?........ Yes No

Drug	Medical Condition Being Treated	Dosage	For How Long

5. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs?........ Yes No
6. Have you been a patient in the hospital during the past five years?........ Yes No
7. Do you get headaches? Yes No How often? ______________
8. Does anything trigger your headaches? ______________
9. To what degree would you say your headaches affect your life? ______________
10. On a scale of one to ten, what is the range of your headaches? ______________
11. Have you been treated or evaluated for your headaches? ______________
12. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)...	Yes No	Ulcers........	Yes No	Hepatitis A B C (Circle)........	Yes No
Chest Pain or Angina........	Yes No	Diabetes........	Yes No	Take Blood Thinners........	Yes No
Congenital Heart Disease........	Yes No	Thyroid Problems........	Yes No	A.I.D.S/H.I.V. Positive........	Yes No
Heart Murmur........	Yes No	Glaucoma........	Yes No	Cold Sores/Fever Blisters........	Yes No
High/Low Blood Pressure........	Yes No	Contact lenses........	Yes No	Anemia or Blood Disorder........	Yes No
Endocarditis........	Yes No	Emphysema/Lung Illness........	Yes No	Hemophilia........	Yes No
Artificial Heart Valve/Transplant..	Yes No	Chronic Cough........	Yes No	Sickle Cell Disease........	Yes No
Snoring or Sleep Apnea........	Yes No	Tuberculosis........	Yes No	Bruise Easily........	Yes No
Arthritis/Rheumatism........	Yes No	Asthma........	Yes No	Liver Disease/Yellow Jaundice.....	Yes No
Cortisone Medicine........	Yes No	Hay Fever/Allergy/Hives........	Yes No	Neurological Disorders........	Yes No
Pacemaker........	Yes No	Latex Sensitivity........	Yes No	Epilepsy or Seizures........	Yes No
Stroke........	Yes No	Sinus Trouble........	Yes No	Fainting or Dizzy Spells........	Yes No
Slow Healing Mouth Sores........	Yes No	Radiation Therapy........	Yes No	Nervous/Anxious........	Yes No
Alcohol / Drug Use........	Yes No	Chemotherapy........	Yes No	Psychiatric/Psychological Care.....	Yes No
Kidney Disease........	Yes No	Cancer or Tumors........	Yes No		

Heart Stent?........ Yes No When placed? __________
Artificial Joints (hip, knee)........ Yes No When placed? __________

13. Are you aware of having an allergic (or adverse) reaction to any substance or medication?........ Yes No
    If yes, please list ______________
14. Have you lost or gained more than 10 pounds in the last year?........ Yes No
15. Do you have or have you had any disease, condition or problem not listed?........ Yes No
    If yes, please list: ______________
16. Women: Are you pregnant or think you could be pregnant? Yes ______ Months No Nursing?........ Yes No
17. Do you use birth control prescriptions........ Yes No
18. Do you use tobacco? ________ In what form? ________ How much per day? ________ For how long? ________

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 knowlegde. 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 change in my health or medication.

Patient/Guardian Signature ______________ Date ______________