

## Medical History

Last name: \_\_\_\_\_ First: \_\_\_\_\_ Birth date: \_\_\_\_\_

Who should we contact in an emergency? \_\_\_\_\_ Phone: \_\_\_\_\_

Are you currently under treatment or therapy? \_\_\_\_\_ For what? \_\_\_\_\_

Physician's name: \_\_\_\_\_ Phone: \_\_\_\_\_

Medications you are currently taking, including herbal supplements & over-the-counter drugs: \_\_\_\_\_

Do you have or have you had:	No	Yes	Date	Comments
Heart trouble _____				
High blood pressure _____				
Low blood pressure _____				
Heart implant (valve, stent, pacemaker) _____				
Joint replacement _____				
Lung disease _____				
Tuberculosis _____				
Emphysema _____				
Asthma _____				
Seasonal allergies _____				
Seizures or Epilepsy _____				
HIV or AIDS other STD _____				
Liver disease _____				
Hepatitis (type) _____				
Major surgery (type) _____				
Blood transfusion _____				
Blood disorder (anemia, leukemia) _____				
Bleeding problems _____				
Diabetes _____				
Glaucoma _____				
Arthritis (type) _____				
Cancer (type) _____				
Chemotherapy _____				
Radiation therapy _____				
Thyroid disorder _____				
Kidney disorder _____				
Stomach ulcers _____				
Mouth ulcers _____				
Osteoporosis _____				
* Ever taken Bisphosphonates _____				
Drug or alcohol abuse _____				
Emotional or Psychological Disorder _____				
Any other medical conditions _____				

Initial \_\_\_\_\_

Have you ever had a reaction to:	No	Yes	Describe
Penicillin _____			
Erythromycin _____			
Tetracycline _____			
Codeine _____			
Aspirin _____			
Acetaminophen _____			
Ibuprofen _____			
Sulfa _____			
Metals _____			
Latex _____			
Phisohex _____			
Acrylic _____			
Other _____			

Do you use:	No	Yes	Type	Quantity
Tobacco _____				
Alcohol _____				
Drugs _____				

Are You:	No	Yes
Hearing impaired: _____		
Visually impaired: _____		
Other disabilities: _____		

Have you been diagnosed or do you suspect that you have a sleeping disorder? \_\_\_\_\_

Are you aware that there is a detrimental relationship between gum disease and systemic diseases such as Diabetes and Heart disease? \_\_\_\_\_

Women:	No	Yes	Due Date:
Are you pregnant? _____			_____
Are you taking hormone replacement? _____			Type _____
Are you taking birth control pills? _____			Type _____

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor's notes:  
 B.P. \_\_\_\_\_ ASA \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

For Medical Update Use Only:

Patient's Signature \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date: \_\_\_\_\_