PATIENT MEDICAL HISTORY

Patient Name:_____Date of Birth_____Male _____ Female

Medical History: Check the box ONLY if you have now, or have had in the past.

CARDIOVASCULAR (heart**)**
□High blood pressure □
□Irregular heart beat,□ pacemaker□
□Chest pain □ □Heart attack □
□Mitral Valve Prolapse □
□Heart murmur □
□Heart surgery: bypass, transplant□

PULMONARY (lungs**)**
□Asthma □
□Emphysema, bronchitis □
□Pneumonia □
□Tuberculosis □
□PPD+ □

DERMATOLOGY (skin) □rash/hives/sores

NERVOUS SYSTEM
□Alzheimer's □ □Anxiety □
□Depression □ □Seizure □

□Headaches □ □Stroke □
□Parkinsons, MS, Cerebral Palsy □
□Muscular dystrophy □

GASTROINTESTINAL (digestive**)**
□Hepatitis □ □Anorexia □

□Cirrhosis □ □ Bulimia □
□Ulcer □
□Transplant: liver; kidney □
□Heart burn (reflux) □

□**SURGERY:**_____
_____

□Hospitalization: recent/past
Are you under a physician's care? □yes□no
Physician's name:_____
Do you have any other health problems not listed that we should know about? □yes□no
Explain_____

GENITOURINARY (kidney, urinary**)**
□Dialysis □ □Syphilis □□Gonorrhea □□Herpes□

ENDOCRINE
□Diabetes □ □Thyroid □
□ Prostate □ □Hypothyroid disorder□□Prosthetic heart valve □

MUSCULOSKELETAL
□Artificial joints □ Arthritis Degenerative/Rheumatoid□ Osteoporosis□

IMMUNE SYSTEM: Are you allergic to or have had a reaction to:
Penicillin or other antibiotics□ Sulfa drugs□ Aspirin□ Codeine□ Latex□
Local anesthetics / novocaine□ any metals□ Barbiturates / sedatives or sleeping pills□
Other_____
Do you have or have ever had the following: □Lupus □HIV □Sjogren's syndrome

HEMATOLOGIC (blood)
□Anemia□ Bleeding disorder□ □Bruise easily□
□Hemophilia□ □Blood transfusion□ □Leukemia / blood cancer□
□Sickle cell anemia□ HIV□

Have you ever had abnormal bleeding or any complications after dental procedure or surgery? □yes □no Explain:_____
_____

CANCER: □ any history of cancer . If so Explain_____
_____

DRUG USE: Do You Use ? Alcohol____ Tobacco___

WOMEN: □I am pregnant or possibly pregnant □ I am nursing □ Post-menopause □ Oral contraceptive

Are you taking or have ever taken the following oral or intravenous BISPHOSPHONATES medications which are associated with Osteoporosis and Cancer Treatment:
ORAL: □Fosamax □Actonel □Boniva □Didronel □Skelid □Other_____

INTRAVENOUS: □Zometa□□Aredia□□Didronel □Bonefos □Other_____

DO YOU TAKE PRESCRIPTION DRUGS? OR SUPPLEMENTS?

□ NO
□ YES **(LIST BELOW)**

_____
_____
_____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. If I ever have any changes in my health, I will inform the doctor.

Signature_____Date_____