Patient Name (First & Last) _____ Age _____

Weight _____ Height _____

Medical Doctor _____ Address _____

Dentist _____ Address _____

Orthodontist _____ Address _____

MEDICAL HISTORY

Do you have or have you ever had any of the following - Please check

Y	N		Y	N		Y	N	
___	___	Allergies to *drugs (list below)	___	___	Excessive Bleeding from a cut or extractions, von Willebrand	___	___	Heart Attack
___	___	Allergy to Latex	___	___	Liver Disorder	___	___	High Blood Pressure
___	___	Allergies to anesthetics	___	___	Hepatitis A, B, C	___	___	Stroke
___	___	Allergy to eggs	___	___	HIV Disease (AIDS)	___	___	Malignancies
___	___	Allergy to IV dyes (iodine)	___	___	Epilepsy, Convulsions	___	___	Radiation Treatments
___	___	Allergy to hard shell fish	___	___	Neurological Problems/Seizures	___	___	Recurrent Infections of any kind
___	___	Mitral Valve Prolapse			Type of seizures _____	___	___	Thyroid
___	___	Pacemaker	___	___	Arthritis	___	___	Ulcer or Colitis / Stomach Problems, Reflux Disease
___	___	Heart Murmur	___	___	Psychiatric Care/Emotional Problems	___	___	Kidney Disease
___	___	Rheumatic Fever	___	___	Alzheimer / Dementia	___	___	Artificial Joints or Valves
___	___	Heart Valve	___	___	Anxiety / Depression	___	___	Diabetes
___	___	Asthma/Emphysema	___	___	Mental Retardation	___	___	Eye Problems/Glaucoma
___	___	Tuberculosis	___	___	Clicking or Popping of Jaw Joint	___	___	Are you pregnant?
___	___	Sleep Apnea / Snoring (Circle one or both)	___	___	Difficulty Opening Mouth/ Grind or Clench Teeth			If so, what month _____
___	___	Nasal / Sinus Problems				___	___	Are you nursing?
___	___	Seasonal Allergies						

Are you taking or *have you ever taken* Bisphosphonates for osteoporosis, multiple myeloma or other cancer? ☐ YES ☐ NO

(Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa) _____

Do you smoke/chew tobacco? _____ How much? _____ Alcohol? _____ How much? _____

Do you use (even casually) Marijuana or Street Drugs? (strictly confidential) _____ How much? _____

_____

*Are you Allergic to any medication? (If so, please list _____

_____

Please list all Surgeries. _____

_____

Please list all Medical Disorders. _____

_____

Please list ALL medications you are currently using, including Herbal Medications, Vitamins, and Over-The-Counter medication.

_____

_____

Reason for your visit today. _____

Date _____ Signature _____