Patient Medical History

Patient Name_____Age_____Today's Date _____

→ Are You ALLERGIC to or have you had any REACTIONS to any of the following?

	YES	NO
1. Local Anesthetics (e.g. Novocain)?	1. ____	____
2. Penicillin?	2. ____	____
3. Amoxicillin?	3. ____	____
4. Sulfa Drugs?	4. ____	____
5. Codeine?	5. ____	____
6. Aspirin?	6. ____	____
7. Egg Products?	7. ____	____
8. Adhesive Tape?	8. ____	____
9. Latex Rubber?	9. ____	____
10. Others not listed? _____		

→ Are you taking any MEDICATION(S)? _____ If Yes, what? _____
_____

→ Have you ever taken Fosamax, Boniva, Actonel, Zomata, Aredia or any medications containing Bisphosphonates? _____ YES ____ NO (for Osteoporosis or other bone disorders)

→ Have you ever had difficulty with, or a bad reaction to General Anesthesia? _____
IF so, What? _____

→ Have you had any surgical operations? _____ If Yes, What for and when? _____
_____

→ Have you had ANY heart valve, open heart surgery or joint replacement? _____ If so, what and When? _____

→ Is there a chance you may be pregnant? _____ If so how many months? _____

→ Do you use Tobacco, Smoke Cigarettes, Use Controlled Substances, and Alcohol? (Please Circle)
How much? _____

→ Do you have any of the following or have had in the past? (**Please Circle**).

Heart Attack _____ (yr)	Cancer(Now) (Past)	Epilepsy/Convulsions	Fainting Spells
Stroke _____ (yr)	Radiation Therapy	Asthma	TMJ Symptoms
High Blood Pressure	Kidney Failure/Transplant	Rheumatic Fever	Sever Weight Loss
Heart Disease	Hepatitis A,B, or C	Stomach Ulcers	Depression
Chest Pains	AIDS or HIV	Emphysema	Bleeding Disorder
Angina	Diabetes	Thyroid Problem	Heart Murmur
Taking Blood Thinners	Lupus	Arthritis	Psychiatric Disorder
Mitral Valve Prolapse	Liver Disease	ADD/ADHD	Tuberculosis
Cardiac Pacemaker			

Authorization and Release

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 authorize the dentist to release any information to third party health practitioners.

X _____ (Signature of Patient (or parent/guardian if minor)