MEDICAL HEALTH HISTORY

Patient full name____

Physician's name____

Have you been hospitalized in the past 2 years?...yes no

Have you been under a doctor's care in the past 2 years (other than routine)?............yes no

Nature of care____

Are you currently taking any medications and supplements?..yes no

If so, please list:_______________________________ _________________________________

_______________________________ _________________________________

_______________________________ _________________________________

_______________________________ _________________________________

Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? yes no

If yes, how long?___________________________

Are you allergic to or have sensitivity to any of the following? Please circle "yes" or "no" to each item

yes no latex
yes no codeine
yes no erythromycin
yes no lidocaine
yes no penicillin
yes no amoxicillin
yes no sulfa
yes no vicodin

yes no aspirin/advil/tylenol
yes no clindamycin
yes no percocet
yes no other_____________

Indicate which of the following you have had or have at present. Please circle "yes" or "no"

yes no arthritis
yes no osteoporosis

yes no stroke
yes no tobacco use

yes no cancer/tumor

yes no chemo/radiation

yes no leukemia
yes no tuberculosis

yes no shortness of breath yes no asthma

yes no bronchitis

yes no emphysema

yes no kidney disease

yes no hemophilia

yes no diabetes

yes no anemia

yes no thyroid problems
yes no jaw or joint pain

yes no cold sores

yes no liver disease
yes no drug/alcohol addiction

yes no hepatitis A B C

yes no blood transfusion

yes no epilepsy/fainting spells

yes no heart attack
yes no heart arrhythmia
yes no high blood pressure

yes no heart disease
yes no artificial valve
yes no congenital heart defect

yes no heart murmur
yes no pacemaker

other conditions not listed____

yes no **artificial joints (ex: knee or hips)**_________________________________ date of surgery_______________

Have you been advised to take antibiotics before dental treatment? yes no

WOMEN ONLY: Are you taking birth control pills? yes no Are you pregnant? yes no Month?_________