# Medical History

Patient's name_____ Address _____City_____

Zip_____ Cell#_____ Email address_____

Approximate date of last medical examination_____ Are you now under current medical treatment or care ? **No** or IF **Yes** Medical doctor's name _____Doctors Office #_____

Medication that you are currently taking?_____

_____

Are you taking OR have taken Phen-Phen or medications for Osteoporosis, like *Fosamax*, **NO** if **Yes** When? _____

**Allergic to** any **Medications**? _____ If yes what? _____

Have you ever had a bad **reaction** to any drugs or anesthetic? ____If yes **what** and _____ **when**? _____

Do you have any **Implants** or Artificial Heart Valves, Hip, Elbows, Knees, Pacemaker or any Metal in your body? _____ If yes, what and when placed? _____ Do you require **Pre-Med** (antibiotics) for this prior to having any dental treatment? **Yes** **No**

Treating doctor's name_____ Office #_____

Address_____

Do you have any of the following

| | | | | | |
|---|---|---|---|---|---|
| Heart Ailments or Defects? | Yes | No | Diabetes? | Yes | No |
| Stents in your heart? | Yes | No | High blood pressure? | Yes | No |
| History of fainting? | Yes | No | Allergies to latex? | Yes | No |
| Allergies to Metals/ Jewelry? | Yes | No | Do you bleed easily? | Yes | No |
| Do you take a blood thinner? | Yes | No | | | |

Communicable disease? Such as: Hepatitis, V.D., AIDS or T.B.?_____

Are you pregnant or trying? (Women) Yes No If yes, how far along? _____

Are you the recipient of an organ transplant? Yes No

Is there anything else you would like Dr. Woodill to know or discuss? If so, please list. _____

_____

Signature_____ Date:_____

Dr. David Woodill DDS _____Date:_____