Medical History

Please complete the following:

Patient's name_____________________________ Phone# (where we can reach you)_______________

Address_______________________________________ City____________________ ZIP___________

Approximate date of last physical examination_________________________

Are you now under current medical treatment or care ? NO or YES If Yes

Medical doctor's name _____________________________________ Phone #___________________

Medication that you are currently taking?____

____

are you taking or have taken ***Fosamax*** or **Phen-Fen?** _______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?____________________________________

Treating doctor's name_______________________

Phone number of treating doctor ________________ Address_________________________________

Do you require **Pre-Med** (antibiotics) prior to having any dental treatment? **Yes** **No** (for example, have you had a knee or hip replacement, or stents placed in your heart)

Do you have any Heart Ailments or Defects Yes No

Do you have any Stents in your heart? Yes No

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

Do you have high blood pressure? Yes No

Do you bleed easily? Or Take Blood Thinner Yes No

Do you have a history of fainting? Yes No

Do you have diabetes? Yes No

Do you have a **Latex** allergy? Yes No

Do you have any allergies to Metals/ Jewelry/Iodine Yes No

Do you have asthma Yes No

Do you have or have had Liver disease, Kidney disease, Hepatitis, V.D. AIDS, or T.B.?____

Signature____ Date____________________