Medical History

In order for us to provide you with the safest and best possible care, please complete these Medical & Dental History forms. All information is kept strictly confidential.

Have you taken any prescription drugs during the last 6 months? Please list. ____________________ **YES NO**

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Are you taking any over the counter medications or herbal supplements? Please list. ____________ **YES NO**

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Are you allergic to (i.e. itching, rash, swelling of hands, feet, eyes) or made sick by any medication? **YES NO**

Please list ____

Any surgeries and/or hospitalizations? ____ **YES NO**

Have you ever had any excessive bleeding requiring special treatment? ___________________________ **YES NO**

Have you ever taken drugs by mouth or by injection to strengthen bone for conditions such as osteoporosis, multiple myeloma, Paget's disease, breast or prostate cancer? _____________________ **YES NO**

Have you ever been told to take antibiotics prior to dental treatment? **YES NO**

Use of alcohol: **YES NO |** **Daily Weekly Monthly** Use of recreational drugs: **YES NO**

Do you use tobacco? What type and how much per day? ____ **YES NO**

If allergic to please circle: Metal Acrylic Latex Local Anesthetics

CIRCLE ANY OF THE FOllOWING WHICH YOU HAVE AT THE PRESENT OR HAVE HAD IN THE PAST:

Low/High Blood Pressure	**Kidney Problems**	**Diabetes TYPE I OR II**	**Anemia**
Heart disease/ Attack	**Sexually Transmitted Diseases**	**Thyroid Gland Problems**	**Leukemia**
Angina Pectoris	**Bruise/Bleed Easily**	**Acid Reflux**	**Osteoporosis**
Seizures/Epilepsy	**Artificial Heart valve**	**Ulcers**	**Hepatitis**
Stroke	**Asthma/ Bronchitis**	**Arthritis**	**Chemotherapy**
Heart Pacemaker	**Emphysema /COPD**	**Heart Surgery**	**Liver Failure**
Radiation Treatment	**Heart Failure**	**Auto-Immune disease**	**Cancer**
Allergies/Sinus Trouble	**Artificial Heart Value**		

Other____

Are you pregnant now? **YES NO** Practicing birth control? **YES NO** Plan to become pregnant? **YES NO**

Please Read the Following Carefully:

To the best of my knowledge all of the preceding answers are true and correct. If I ever have a change in my health, I will inform the office at the next appointment. I do hereby authorize and request for myself or the above named patient, dental services and/or whatever procedures the doctor may deem necessary. I also authorize the administration of those local anesthetic or pre-medications which may be deemed advisable.

____ _____________________________

Signature of Patient or Guardian Date