

History and Medications

Name _____
 Phone Number _____
 Employer _____
 Occupation _____
 Marital Status _____

Date _____
 Dentist name _____
 Physician _____
 Birthdate _____
 Age _____

	YES	NO
Do you consider yourself in good health?	_____	_____
Are you subject to prolonged bleeding?	_____	_____
Are you pregnant?	_____	_____
Do you have a prosthetic hip or knee? If yes, what year was the surgery? _____	_____	_____
Do you have a cardiac pacemaker?	_____	_____
Do you have a prosthetic heart valve?	_____	_____
Do you have a heart murmur?	_____	_____
Have you ever taken biophosphonates or other drugs like Fosamax to prevent or treat bone problems?	_____	_____
Are you allergic to Latex?	_____	_____
Can you take ibuprofen?	_____	_____

Please indicate if you have a history of:		
	YES	NO
Hepatitis	_____	_____
Tuberculosis	_____	_____
Kidney Trouble	_____	_____
Liver Trouble	_____	_____
Epilepsy	_____	_____
G.I. Ulcers	_____	_____
GERD	_____	_____
AIDS/HIV	_____	_____
High Blood Pressure	_____	_____
Diabetes	_____	_____
Blood Disorders	_____	_____
Fainting Spells	_____	_____
Radiation Therapy	_____	_____
Chemotherapy	_____	_____
Glaucoma	_____	_____
Asthma	_____	_____

<p>Please list all allergies:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>Please list any other illnesses, etc.:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>

CURRENT MEDICATIONS	CONDITION YOU TAKE IT FOR
_____	_____
_____	_____
_____	_____
_____	_____

Patient, Parent (or Guardian) Signature: _____ Dr. Signature _____
