History and Medications

Name______________________________________ Date________________________________
Phone Number______________________________ Dentist name__________________________
Employer__________________________________ Physician_____________________________
Occupation________________________________ Birthdate_____________________________
Marital Status_____________________________ 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	______	______

Please list all allergies:

____
____
____
____

Please list any other illnesses, etc.:

____
____
____
____
____

CURRENT MEDICATIONS	CONDITION YOU TAKE IT FOR
______________________________________	______________________________________
______________________________________	______________________________________
______________________________________	______________________________________
______________________________________	______________________________________

Patient, Parent (or Guardian) Signature: ______________________________

Dr.Signature____