CONFIDENTIAL MEDICAL HISTORY

Patient's name_____ Today's date _____
Date of birth _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you many have, or medication that you may be taking, could have an important interrelationship with the dental care that you will be receiving. Thank you for answering the following questions.

1. Are you in good health? *yes/no* 2. Have there been any changes in your general health within the past year? *yes/no* If yes, please explain .... 2a. Do you exercise regularly? *yes/no* 2b. If so, how?	9. Are you taking any medications (pills) including over-the-counter medicine like aspirin? *yes/no* If yes, what? .... Are you taking vitamins or herbal supplements? *yes/no*
3. Date of your last physical exam: ..... 4. Are you under the care of a physician? *yes/no* If so, for which condition?.....	10. Have you had a recent unexpected weight loss? *yes/no* 11. Have you ever taken Fen-Phen or Redux for weight loss? *yes/no*
5. Physician's Name ..... Address ..... City ..... Phone number ..... Years under care ..... Any other specialist?	12. Do you use tobacco? *yes/no* If yes, for how long?..... What type? ..... 13. Do you now take drugs or used drugs for recreational use? *yes/no* What type?..... 14. Have you had any abnormal bleeding? *yes/no*
6. Have you ever been hospitalized for any surgical operation or serious illness? Please explain.	15. Do you have any disease, condition or problem not listed above that you think I should know about? ....
7. Have you ever required a blood transfusion? *yes/no* If so, when? ..... 8. Do you bruise easily? *yes/no*	16. Have you taken Fosamax, Actonel, Boniva or Didronel for Osteoporosis? ....
WOMEN ONLY: Is there a chance that you are pregnant? *yes/no* Are you nursing? *yes/no* Are you taking birth control pills? *yes/no* Are you receiving fertility drugs? *yes/no*	17. Have you received similar medications, Zometa or Aredia through an IV line? .....

ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:

Local anesthetics like novocaine *yes/no*
Penicillin or other antibiotics *yes/no*
Sulfa drugs *yes/no*
Pills to help you sleep *yes/no*
Aspirin *yes/no*
Iodine *yes/no*
Any metals (E.G. nickel) *yes/no*
Latex/rubber *yes/no*
Seasonal *yes/no*
Other (please list) .....

DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING (list when):

1. Echo Cardiogram (not EKG) .....
2. Mitral valve prolapse .....
3. Artificial heart valves .....
4. Rheumatic heart disease or rheumatic fever .....
5. Scarlet fever .....
6. Heart defect or heart murmur .....
7. Heart trouble, heart attack, or angina ....
8. Chest pain .....
9. Shortness of breath .....
10. Persistent cough .....
11. Cough that produces blood .....
12. Pacemaker .....
13. Heart surgery .....
14. Hi/low blood pressure .....
15. Congenital heart problem .....
16. Swelling of feet, ankles, hands .....
17. Hepatitis, jaundice or liver disease .....
18. Stroke/Aneurysm .....
19. Hypoglycemia .....
20. Hives or skin rash .....
21. Fainting or dizzy spells .....
22. Diabetes .....
    Family History of Diabetes?.....
23. AIDS, HIV or Hepatitis contact .....
24. AIDS, HIV or Hepatitis positive antibody .....
25. Thyroid problems .....
26. Blood Disorders .....
27. Arthritis or rheumatism (what area?).....
28. Joint replacement or implant (list what area and date of surgery) .....
29. Stomach ulcer .....
30. Kidney/urinary problem .....
31. Cancer .....
32. Chemotherapy .....
33. Sexually transmitted disease .....
34. Epilepsy or seizures .....
35. Anemia .....
36. Glaucoma .....
37. Nervousness, anxiety, phobias .....
38. Tumors .....
39. Depression or related mental health issues .....
40. Back problems .....
41. Chemical dependency .....
42. Sinus trouble/infections .....
43. Lung or breathing problems .....
44. Asthma or hay fever .....
45. Cortisone, Prednisone or other steroids .....
46. Cold Sores/fever blisters .....
47. Eating disorders .....
48. Do you use antacids regularly? Yes/*No*
49. Sleep Apnea (C-Pap)_.....
50. Sleep Apnea sleep test? Yes/No

For any of the above conditions that require additional explanation, please do so below, and include the corresponding number.

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Signature_____Date_____

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