MEDICAL INFORMATION

Physician_____ Office Phone_____ Date of last exam_____

Are you currently under medical treatment? _____ yes _____ no If yes, please add to “Notes” section.

Do you use tobacco? _____ yes _____ no In what form? _____ How much? _____ How long? _____

Have you ever used or are you currently using any recreational drugs? _____ yes _____ no

Do you have any drug, latex, metal or food allergies? _____

Are you taking or have you taken oral bisphosphonates? (e.g. Fosamax, Actonel, Boniva, Didrone, Aredia, Zometia, Skelid?

Women only: Are you pregnant?_____ Nursing?_____ Taking birth control?_____

Please circle if you have had or have any of the following:

Abnormal bleeding*	Epilepsy	Mitral valve prolapse*
Alcohol/Drug Abuse	Fainting spells	Pneumocystis
Anemia	Fever blisters	Pre-Med
Angina pectoris	Frequent headaches	Psychiatric problems
Arthritis	Glaucoma	Radiation therapy
Artificial joints*	Heart attack*	Rheumatic fever*
Artificial heart valve*	Heart disease*	Seizures
Asthma	Heart surgery*	Sickle cell disease
Cancer/chemotherapy*	Hepatitis*	Sinus problems
Colitis	HIV or AIDS*	Stents/shunts*
Congenital heart defect*	High blood pressure*	Stroke*
Defibrillator/Pace maker	TMD/ Jaw problems	Thyroid problems
Diabetes*	Kidney problems	Tuberculosis
Difficulty breathing	Liver disease	Ulcers
Emphysema	Low blood pressure	Venereal disease

* May need physician clearance prior to dental treatment

Are you currently taking any medications? _____ yes _____ no If yes, please list:

Is there any disease, condition, or problem that was not specifically addressed above that you think this office should know about? If yes, please describe below:

I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge.

Signature_____ Date_____

(If under 18 parent or guardian signature required)