Dental / Medical History

Patient Name _____

1, Are you taking any medications? If so, What? (Please attach additional sheet if necessary)

_____ YES / NO

2, Are you allergic to or have had a reaction to any medication or drug? YES / NO

If so, What?_____

3, Have you been under a physician care in the past 2 years? YES / NO

If so, Why? _____

4, Have you been hospitalized in the past 2 years YES / NO

If so, Why? _____

5, Do you have or have you ever had a heart murmur or been treated for a

heart condition in the past 2 years? If so, When _____ YES / NO

6, Have you ever been treated for a tumor, growth, or Cancer? YES / NO

7, Have you ever had excessive or prolonged bleeding?

as a result of a medical condition or medication? YES / NO

(example: Hemophilia or blood thinners)?

8, Do you have a latex allergy? YES / NO

9, Do you have or have ever had a stint, shunt, or artificial joint? YES / NO

10, Women Only: Are you pregnant? YES / NO

If so, Due Date _____

11, Are you now or have ever taken the following medications: Fen-Phen, Redux, Pondimin, Aredia,

Fosamax, Zometa, Actonel, or Boliva? YES / NO

12, Are you now or have ever been treated for Drug Dependency or Alcoholism or taken Narcotics in the last 6 months? YES / NO

If so, what kind? _____

13, Are you now or have been on Narcotics for any reason in the last YES / NO

6 months? if so what kind? _____