Medical History

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Name_____ **E-Mail:**_____

Phone #'s Phone #'s (Home) _____ **Cell** _____ **Work**_____

1. Have you been under a doctor's care during the past year? Y☐ N☐ If yes, please explain _____
2. Have you ever been hospitalized? Y☐ N☐ If yes, please explain_____
3. Have you ever had any operations? Y☐ N☐ If yes, please explain_____
4. Have you ever had any of the following? **(Please check Y or N for each one)**

Heart Disease	Y☐ N☐	Tobacco (smoking/ chew)	Y☐ N☐	Sinus	Y☐ N☐
Open heart surgery	Y☐ N☐	Asthma	Y☐ N☐	Bleeding Disorder	Y☐ N☐
Pacemaker	Y☐ N☐	Respiratory problems, i.e.; emphysema, bronchitis	Y☐ N☐	Anemia	Y☐ N☐
Heart murmur	Y☐ N☐	Stomach ulcers	Y☐ N☐	Bone Disorder	Y☐ N☐
Mitral Valve Prolapse	Y☐ N☐	Liver Disease (cirrhosis, hepatitis)	Y☐ N☐	Artificial Joints	Y☐ N☐
High Blood Pressure	Y☐ N☐	Diabetes	Y☐ N☐	TMJ	Y☐ N☐
Seizures/fainting	Y☐ N☐	Thyroid	Y☐ N☐	AIDS or HIV	Y☐ N☐
				Radiation Therapy	Y☐ N☐

5. Have you had any disease, drug or transplant operation that has depressed your immune system? Y☐ N☐
If yes, please explain: _____
6. Are you taking Bisphosphonates (Fosamax, Boniva, Actonel, Aredia, Zometa, Reclast, Prolia) for osteoporosis, chemotherapy or multiple myeloma, etc.? Y☐ N☐
7. Do you have any past history of chemical or alcoholic dependency that may affect the care we provide? Y☐ N☐
8. Are you taking any of the following?

Anticoagulants(blood thinners)	Y☐ N☐	Steroids (Cortisone, etc.)	Y☐ N☐
Aspirin/drugs (Motrin, Aleve, Ibuprofen)	Y☐ N☐	Tranquilizers	Y☐ N☐
High blood pressure drugs	Y☐ N☐	Antibiotics	Y☐ N☐
Insulin or Oral Anti-Diabetic drugs	Y☐ N☐	Digitalis, Inderal Nitroglycerin or other heart drugs	Y☐ N☐

9. Please list any and all medications you are currently taking, including prescription medications, over-the-counter medications, herbal or holistic remedies, vitamins or minerals _____
_____
_____
10. Are you allergic or have you had an adverse reaction to:

Local anesthesia (Novocain, etc.)	Y☐ N☐	Other antibiotics?	Y☐ N☐	Codeine or other pain killers	Y☐ N☐
Penicillin/ Amoxicillin	Y☐ N☐	Aspirin or Ibuprofen	Y☐ N☐	Sedatives, barbiturates	Y☐ N☐
Other allergies or reactions?	Y☐ N☐	Latex or Rubber Products	Y☐ N☐	Please List:_____	

11. For Women Only: Are you pregnant/any chance you might be pregnant? Y☐ N☐ Are you nursing? Y☐ N☐
**If you are using Oral Contraceptives, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Please consult with your physician.

Pharmacy: _____ **Pharmacy # :** _____
I understand the importance of a truthful health history to assist the doctor to provide the best care possible. I have had to opportunity to discuss my health history.
Signature: _____ **Date:** _____