Have you ever had any of the following diseases or medical problems?

Y	N	Abnormal Bleeding	Y	N	Hepatitis
Y	N	Alcohol/Drug Abuse	Y	N	Herpes/Fever Blisters
Y	N	Anemia	Y	N	High Blood Pressure
Y	N	Arthritis	Y	N	HIV+/AIDS
Y	N	Art. Bones/Joints/ Valves	Y	N	Hospitalized for any reason
Y	N	Asthma	Y	N	Kidney Problems
Y	N	Blood Transfusion	Y	N	Liver Disease
Y	N	Cancer/Chemotherapy	Y	N	Low Blood Pressure
Y	N	Colitis	Y	N	Mitral Valve Prolapse
Y	N	Congenital Heart Defect	Y	N	Pacemaker
Y	N	Diabetes	Y	N	Psychiatric Problems
Y	N	Difficulty Breathing	Y	N	Radiation Treatment
Y	N	Emphysema	Y	N	Rheumatic/Scarlet Fever
Y	N	Epilepsy	Y	N	Seizures
Y	N	Fainting Spells	Y	N	Shingles
Y	N	Frequent Headaches	Y	N	Sickle Cell Disease/Traits
Y	N	Glaucoma	Y	N	Sinus Problems
Y	N	Hay Fever	Y	N	Stroke
Y	N	Heart Attack	Y	N	Thyroid Problems
Y	N	Heart Murmur	Y	N	Tuberculosis (TB)
Y	N	Heart Surgery	Y	N	Ulcers
Y	N	Hemophilia	Y	N	Venereal Disease (STD)

PLEASE LIST ANY SERIOUS MEDICAL CONDITION(S) THAT YOU HAVE EVER HAD: _____

_____

Are you taking any prescription/over-the-counter or herbal supplement drugs? Please List:

_____

_____

_____

Have you ever taken Fosamax, or any other bisphosphonate? _____

Have you ever taken Phen-fen?

FOR WOMEN: Are you using a prescribed method of birth Control? Y N

Are you Pregnant? Y N

Are you Nursing? Y N

Are you **allergic** to any of the following?

Y	N	Aspirin
Y	N	Codeine
Y	N	Dental Anesthetics
Y	N	Erythromycin
Y	N	Jewelry
Y	N	Latex
Y	N	Metals
Y	N	Penicillin
Y	N	Tetracycline

Please list any other drugs/materials that you are allergic to:

_____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and, treatment with my informed consent.

_____

Signature Date

OFFICE USE ONLY:

I verbally reviewed the medical/dental information above with the patient named herein. Initials _____ Date _____

Doctor's Comments:_____

_____

_____

_____

_____