

Patient Name _____

Health History

Are you currently under a physician's care? Yes No

If yes, please explain _____

Have you recently been hospitalized? Yes No

If yes, please explain _____

Are you taking any medications? Yes No

If yes, please list _____

Do you take Aspirin, Coumadin, or Plavix? Yes No

Have you ever taken Fosamax,

Boniva, Actenol or any other medications containing bisphosphonates? Yes No

Do you use tobacco? Yes No

Women Only

Are you:

Pregnant Yes No

Nursing Yes No

Taking Oral Contraceptives Yes No

Are you allergic to any of the following?

Aspirin Penicillin Local Anesthetics Codeine

Acrylic Metal Sulfa Drugs

Other If yes, please explain _____

Medical History

Do you or have you had any of the following?

- | | | |
|--|----------------------------------|------------------------------|
| Yes No Tuberculosis <i>Active? Y N</i> | Yes No Heart Attack | Yes No Mitral Valve Prolapse |
| Yes No Emphysema | Yes No Thyroid Problems | Yes No Kidney Problems |
| Yes No Cardiovascular Disease | Yes No Heart Murmur | Yes No Pacemaker |
| Yes No Sinus Trouble | Yes No Stroke | Yes No Osteoporosis |
| Yes No Angina | Yes No Asthma | Yes No Rheumatic Fever |
| Yes No Artificial Heart Valve | Yes No Hepatitis | Yes No Headaches/Migraines |
| Yes No Congestive Heart Failure | Yes No Low Blood Pressure | Yes No Anemia |
| Yes No Cancer | Yes No Epilepsy | Yes No Glaucoma |
| Yes No Arthritis | Yes No High Blood Pressure | Yes No Hemophilia |
| Yes No Diabetes-Type I or Type II | Yes No Seizures | Yes No STD's |
| Yes No Artificial Joint | Yes No Congenital Heart Disorder | Yes No HIV/AIDS |
| Yes No Ulcers | Yes No Mental Health Disorders | Yes No Shingles |

Dental History

- Yes No Are you happy with your smile?
- Yes No Are you experiencing pain or discomfort?
- Yes No Do your gums bleed when you brush or floss?
- Yes No Do you have any clicking, popping, or discomfort in the jaw?
- Yes No Do you grind your teeth?
- Yes No Do you have sores or ulcers in your mouth?
- Yes No Do you have earaches or neck pain?
- Yes No Have you had orthodontic (braces) treatment?
- Yes No Have you had any problems with previous dental treatments?
- Yes No Have you had periodontal (gum) treatments?
- Yes No Do you wear dentures or partials?
- Yes No Does food or floss catch between your teeth?
- Yes No Are your teeth sensitive to hot, cold, sweets, or pressure?
- Yes No Has a previous physician or dentist recommended that you take antibiotics prior to your dental treatment?
- Yes No Do you or has a doctor prescribed you to use a CPAP machine?

Any additional information you would like us to know:

I understand that the information I have given today is correct to the best of my knowledge. I also understand this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status.

Signature of Patient, Parent or Guardian