Medical Conditions / History

Name: ________________________ **Date of Birth:** __________

Please check Yes or No below:

Y	N		Y	N		Y	N	
☐	☐	Anemia	☐	☐	Glaucoma	☐	☐	Pacemaker/Defibrillator
☐	☐	Angina	☐	☐	Headaches	☐	☐	Radiation Therapy
☐	☐	Arthritis, Rheumatism	☐	☐	Heart Disease	☐	☐	Respiratory Disease
☐	☐	Asthma	☐	☐	Heart Attack	☐	☐	Sinus Problems
☐	☐	Back/Neck Problems			Date: __________	☐	☐	Shortness of Breath
☐	☐	Blood Disease	☐	☐	Hepatitis A/B/C	☐	☐	Sleep Apnea
☐	☐	Cancer (past or present)	☐	☐	High Blood Pressure	☐	☐	Stomach Problems
☐	☐	COPD	☐	☐	HIV or AIDS	☐	☐	Stroke
☐	☐	Recreational Drug Use	☐	☐	Jaundice	☐	☐	Thyroid Disease
		(past or present)	☐	☐	Joint Replacement	☐	☐	Tobacco Habit
☐	☐	Diabetes			Date: ____________			_________________
☐	☐	Epilepsy	☐	☐	Kidney Disease	☐	☐	Tonsillitis
☐	☐	Excessive Bleeding	☐	☐	Liver Disease	☐	☐	Tuberculosis
☐	☐	Fainting	☐	☐	Mental Conditions	☐	☐	Tumors
			☐	☐	Nervous Disorders	☐	☐	Ulcers

Other Medical Conditions not mentioned above:

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Allergies (medications, latex, anesthetics, etc):

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____

____

Current Medications and Vitamins:

____

____

____

____

Women:

Are you pregnant? ___Yes ___No

Due Date: ______________

Are you nursing? ___Yes ___No

Taking Birth Control Pills? ___Yes ___No

Have you been hospitalized or needed emergency care in the past two years? ___Yes ___No

Reason: ______________________________________

History of Bisphosphonate Use: ___Yes ___No

(Including, but not limited to: Fosamax, Boniva, Actonel, Zometa, Aclasta)

Dates taken:___________________

Are you currently under the care of a physician? ___Yes ___No

Name of physician:

____

To the best of my knowledge, all of the preceding answers and information provided are true and correct.
If I ever have any changes to my health, I will inform the dentist and hygienist at my next appointment.

____

Signature of patient or parent/guardian if under 18 *Date*