**Medical History**

Name:­­­­­­­­­­­ Date of Birth:

Address: Social Security No:

 Cell Phone:

Home Phone: Email:

Employer: Employer Address:

Employer Phone:

Referring Dentist: Physician Name and Number:

**Please circle if you have any of the following conditions:**

Heart Disease ---------------------------------------------------------------------------------- YES ------ NO ------

Artificial Joint Replacement ---------------------------------------------------------------- YES ------ NO ------

Heart Valve Replacement ------------------------------------------------------------------- YES ------ NO ------

History of Infective Endocarditis ---------------------------------------------------------- YES ------ NO ------

Do you need Antibiotic Premedication before dental procedure? --------------- YES ------ NO ------

Pacemaker -------------------------------------------------------------------------------------- YES ------ NO ------

Blood Pressure - High/Low ------------------------------------------------------------------ YES ------ NO ------

Hepatitis (Liver Disease) --------------------------------------------------------------------- YES ------ NO ------

Ulcer ---------------------------------------------------------------------------------------------- YES ------ NO ------

Diabetes ----------------------------------------------------------------------------------------- YES ------ NO ------

Kidney Disease --------------------------------------------------------------------------------- YES ------ NO ------

Pregnant/Trimester ------------------------------------------------------------------------- YES ------ NO ------

Thyroid (Hypo/Hyper/Thyroidectomy) -------------------------------------------------- YES ------ NO ------

 ***Please continue other side...***

Glaucoma --------------------------------------------------------------------------------------- YES ------ NO ------

Osteoporosis ----------------------------------------------------------------------------------- YES ------ NO ------

Are you under Medical Treatment Now? -----------------------------------------------YES ------ NO -------

Have you ever been hospitalized for any surgical operation/serious illness within the last 5 years?

----------------------------------------------------------------------------------------------------- YES ------ NO -------

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any Additional Conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Medication**

Allergic to PENICILLIN ------------------------------------------------------------------------------------ YES ------ NO ------

Allergic to Aspirin ------------------------------------------------------------------------------------------ YES ------ NO ------

Allergic to LATEX ------------------------------------------------------------------------------------------- YES ------ NO ------

Allergy to Local Anesthetics ----------------------------------------------------------------------------- YES ------ NO ------

If yes, which anesthetics? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergy to any other medicine? -------------------------------------------------------------------------- YES ------ NO ------

If yes, what medicine? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you ever take an osteoporosis drugs (e.g. Zometa Boniva, Fosamax) ------------------- YES ------ NO ------

Any recent facial trauma or accident? ---------------------------------------------------------------- YES ------ NO ------

**Please List all Medication You are Currently Taking:**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_