MEDICAL HISTORY (Please answer Yes or No)

Are you under a Physician's care now? ____YES____NO IF YES_____
Have you ever been hospitalized or had a major operation? ____YES____NO IF YES_____
Are you taking any medications, pills or drugs? (IF **YES PLEASE LIST**) ____YES_____NO
_____
_____
_____
Have you ever taken **Phen-Fen or Redux**? _____YES ____NO____ N/A
Are you or have you ever taken **Bisphosphonate** medications (**Fosamax, Boniva, Actonel** or **Zometa**) for low bone density? _YES____NO
Are you currently taking any blood thinners **Coumadin (Warfarin), Plavix (Clopidogrel), Xarelto or Heparin**? ____YES____NO
Do you use tobacco? ____YES ____NO

ARE YOU **ALLERGIC** TO ANY OF THE FOLLOWING? IF YOU HAVE ***NO KNOWN* ALLERGIES** CK HERE_____
___Aspirin____Penicillin____Codeine___Acrylic____Metal____Latex____LocalAnesthetic____Clindamycin____Hydrocodone____
Oxydodone____Other_____

WOMEN ONLY **"Y" YES/"N" NO Are you ____Pregnant/Trying to get pregnant? ____Nursing? _____ Taking oral contraceptives?**

PLEASE ANSWER "Y" FOR YES OR "N" NO if you **have**, or **have had**, any of the following?

___AIDS/HIV Positive
___Angina
___Artificial Heart Valve*
___Artificial Joint
___Asthma
___Cancer
___Chemotherapy
___Chest Pains
___Cold Sores/Fever Blisters
___Congenital Heart Disorder*
___Diabetes
___Drug/Alcohol Abuse
___Easily Winded
___Emphysema
___Epilepsy/Seizures
___Excessive Bleeding
___Fainting Spells/Dizziness
___Frequent Headaches
___Glaucoma
___Heart Attack/Failure
___Heart Murmur
___Heart Pace Maker
___Heart Trouble/Disease
___Hemophilia
___Hepatitis A
___Hepatitis B or C
___High Blood Pressure
___Hypoglycemia
___Irregular Heartbeat
___Kidney Problems
___Leukemia
___Liver Disease
___Infective Endocarditis*
___Low Blood Pressure
___Mitral Valve Prolapse
___Pain in Jaw Joints
___ Psychiatric Care
___Radiation Treatments
___Recent Weight Loss
___Renal Dialysis
___Rheumatic Fever
___Scarlet Fever
___Stroke
___Thyroid Disease
___Tuberculosis
___Tumors of Growths
___Ulcers
___Heart Valve Problems*

*The use of preventive antibiotics prior to certain dental procedures is recommended for patients with:

- Artificial heart valves
- a history of infective endocarditis (an infection of the lining inside the heart or the heart valves)
- a cardiac(heart) transplant that develops a heart valve problem
- suffer from a congenital (present from birth) heart condition

Have you ever had any serious illness not listed above? ____YES ____ NO
IF YES, PLEASE LIST: _____ _____

MEDICAL HISTORY UPDATE

We reserve the right to charge and collect a fee of $50.00 for broken appointments without 24 hours notice. The patient is responsible for this charge, neither insurance nor Medicaid will pay this fee. An appointment is a reservation exclusively for you. If you do not give our office at least 24 hours notice of a cancellation it disrupts the practice, as well as denies other patients care. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status, address, phone number or insurance information.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN TODAYS DATE

I have read my medical history dated_____and confirm that it states past and present medical conditions_____
Signature/Date

I have read my medical history dated_____and confirm that it states past and present medical conditions_____
Signature/Date

I have read my medical history dated_____and confirm that it states past and present medical conditions_____
Signature/Date