MEDICAL HISTORY

Physician's Name: _____ Date of Last Visit: _____

Have you ever been told by a physician or dentist that you should be pre-medicated with an antibiotic prior to dental visits? **Yes/no**

1. Are you currently being treated for a medical condition? Yes/no

2. Have you ever had any serious illnesses or operations? Yes/no

3. Are you currently taking any medications? Yes/no

Are you currently taking the medication Fosamax

Or other bio phosphonate? Yes/no

Have you taken Fosamax in the past? Yes/no

Please list all medications: _____

_____

4. Do you take aspirin? Yes/no

5. Do you smoke? Yes/no

Quantity/Frequency? _____

6. Do you use chewing tobacco? Yes/no

Quantity/Frequency? _____

7. Do you use alcohol? Yes/no

Quantity/Frequency? _____

8. Do you use cocaine or other drugs? Yes/no

Quantity/Frequency? _____

9. Do you wear contact lenses? Yes/no

10. Have you had any allergic reactions to the following:

Local Anesthetics (i.e. novacaine)	Yes/no
Penicillin or other Antibiotics	Yes/no
Sulfa Drugs	Yes/no
Latex	Yes/no
Barbiturates (codeine)	Yes/no
Sedatives (valium)	Yes/no
Iodine	Yes/no
Aspirin	Yes/no
Nickel or other metals	Yes/no
Other: _____	Yes/no

11. (Women Only) Are you:

Pregnant?	Yes/no
Nursing?	Yes/no
Taking birth control pills?	Yes/no
Hormone Replacement Therapy?	Yes/no

12. Have you ever taken Phen Phen? Yes/no

13. Do you take herbal supplements? Yes/no

Do you HAVE or have ever HAD:

Aids/HIV	Yes/no	Fainting	Yes/no	Nervous Disorders	Yes/no
Allergies	Yes/no	Glaucoma	Yes/no	Pacemaker	Yes/no
_____		Hay Fever	Yes/no	Radiation Treatment	Yes/no
_____		Head Injuries	Yes/no	Respiratory Problems	Yes/no
Arthritis	Yes/no	Heart Disease	Yes/no	Rheumatic Fever	Yes/no
Artificial Joints	Yes/no	Heart Murmur	Yes/no	Sinus Problems	Yes/no
Asthma	Yes/no	Hepatitis	Yes/no	Stomach Problems	Yes/no
Blood Disease	Yes/no	High Blood Pressure	Yes/no	Stroke	Yes/no
Cancer	Yes/no	Jaundice	Yes/no	Thyroid trouble	Yes/no
Diabetes	Yes/no	Kidney Disease	Yes/no	Tuberculosis	Yes/no
Dizziness	Yes/no	Liver Disease	Yes/no	Tumors	Yes/no
Epilepsy	Yes/no	Mental Disorders	Yes/no	Ulcers	Yes/no
Excessive Bleeding	Yes/no	Mitral Valve Prolapse	Yes/no	Venereal Disease	Yes/no

Other: _____

DENTAL HISTORY

Former Dentist: _____ Date of Last X-rays? _____

City, State: _____ Phone: _____ How often Do You Floss? _____

Date of Last Dental Visit: _____ How Often Do You Brush? _____

Do you need antibiotic pre-medication for dental treatment? Yes/no What was usually prescribed? _____

Circle appropriate answer:

Fingernail biting	Yes/no	Clench/Grind Teeth	Yes/no	Sensitivity when biting	Yes/no
Lip or cheek biting	Yes/no	Orthodontic Treatment	Yes/no	Tooth pain	Yes/no
Dental fears	Yes/no	Frequent headaches	Yes/no	Bad breath	Yes/no
Unfavorable dental experiences	Yes/no	Jaw clicking or pain	Yes/no	Bleeding gums	Yes/no
Blisters on lip or mouth	Yes/no	Sensitivity to cold	Yes/no	Loose teeth	Yes/no
Pain around ear	Yes/no	Sensitivity to heat	Yes/no	Periodontal treatment	Yes/no
Jaw, Head or Neck injuries	Yes/no	Sensitivity to sweets	Yes/no	Broken fillings	Yes/no
Dry mouth, throat and/or eyes	Yes/no	Problems with effectiveness or bad reaction to dental anesthetic?			Yes/no
Unhappy with the appearance of your teeth?		Yes/no	Do new people/places make you anxious?		Yes/no
Unhappy with the color of your teeth?		Yes/no	Do you sweat or tremble during dental exams?		Yes/no
Unhappy with the size/shape/position of your teeth?		Yes/no	Awaken with an awareness of your teeth or jaws?		Yes/no

_____ _____

PATIENT SIGNATURE **DATE**