

MEDICAL HISTORY

Please circle one

Are you under the care of a physician **other** than your routine primary care physician? Yes No

Please list any **medications** that you are now taking, including **vitamins** and **herbs**: _____

Are you **allergic** to any medications? Please list: _____ Yes No

Do you take **aspirin** regularly? Yes No

Do you or a family member have **diabetes**? Relationship: _____ **HbA1c**: _____ Yes No

Have you ever been told you have **high/low blood pressure**? Yes No

Have you ever had any **heart ailments**? Yes No
If yes, please identify: _____

Have you ever had **rheumatic fever, rheumatic heart disease, or a heart murmur**? Yes No

Have you ever had **hip, knee, or other joint replacement**? Yes No

Have you been told to **premedicate** with **antibiotics** for dental procedures? Yes No

Have you ever had any **kidney or bladder** problems? Yes No

Have you ever had any **liver** problems or **hepatitis**? Yes No

Are you **HIV+** or do you have **AIDS**? Yes No

Have you ever had **excessive bleeding, anemia, or any blood problems**? Yes No

Have you had **breathing problems/asthma/ emphysema/TB**? Yes No

Do you **smoke** cigarettes? If yes, how many per day? _____ Yes No

Do you use other **tobacco** products? Yes No

Do you drink alcoholic beverages? If yes, how many per week? _____ Yes No

Do you have **osteoporosis** or **osteopenia**? Yes No

Do you now, or have ever taken **bisphosphonates**? (Fosamax, Actonel, Boniva, Zometa, etc.) Yes No

Are you **pregnant**? Yes No

Have you ever had **major surgery**? Please list and include dates _____ Yes No

Please list any **other** conditions you feel we need to know: _____

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

Print Name: _____ Cell Phone #: _____

Signature: _____ Date: _____