Medical History – Please mark (X) to your response to indicate if you have or have had any of the following

Cancer
Type _____
- ☐ Chemotherapy
- ☐ Radiation Therapy

Cardiovascular
- ☐ Angina (chest pain)
- ☐ Artificial Heart Valve
- ☐ Heart Conditions
- ☐ Heart Surgery
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke

Endocrinology
- ☐ Diabetes
- ☐ Hepatitis A/B/C
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Thyroid Disease

Gastrointestinal
- ☐ Ulcers (Stomach)
- ☐ Gastrointestinal Disease

Hematologic/ Lymphatic
- ☐ Anemia
- ☐ Blood Disorders
- ☐ Bruise Easily
- ☐ Excessive Bleeding

Musculoskeletal
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Jaw Joint Pain
- ☐ Rheumatoid Arthritis

Neurological
- ☐ Anxiety
- ☐ Depression
- ☐ Dizziness
- ☐ Drug/Alcohol Addiction
- ☐ Fainting
- ☐ Seizures
- ☐ Psychiatric Illness

Respiratory
- ☐ Asthma
- ☐ Emphysema
- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Tuberculosis

Viral Infections
- ☐ AIDS
- ☐ HIV Positive
- ☐ HPV

Women
- ☐ Currently Pregnant
- ☐ Nursing

Allergies
- ☐ Antibiotics (Penicillin/Amoxicillin/ Clindamycin)
- ☐ Opiods (Percocet, Oxycodone, Tylenol 3)
- ☐ Latex
- ☐ Local Anesthetics
- ☐ NSAIDs

Other Allergies

_____

_____

Do you use ANY tobacco products:

Y or N

Have you ever been advised to take Pre-Medication (antibiotics) prior to dental appointments. **Y** or **N**

Have you had a serious illness, operation, or hospitalization in the past 5 years? **Y** or **N** If yes please explain:

_____

List any medications you are currently taking:

_____

Have you ever in the past, or are you now currently taking any medication for Osteopenia/Osteoporosis or Bone Disease? If so please list medications: _____

Consent:
The undersigned hereby authorizes Doctor to take x-ray, study models photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.

Signature of Patient/Legal Guardian	Print Name	Date	Dentist Signature
Signature of Patient/Legal Guardian	Print Name	Date	Dentist Signature
Signature of Patient/Legal Guardian	Print Name	Date	Dentist Signature
Signature of Patient/Legal Guardian	Print Name	Date	Dentist Signature