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PATIENT MEDICAL AND DENTAL HISTORY FORM

Patient Name: _____ _____ _____ _____
                     Last   First   MI   Preferred Name

Physician's Name and Date of Last Medical Exam:

_____

_____

List any medications you are currently taking: RX or O-T-C:

_____

_____

_____

List any medications you are allergic to:

_____

_____

Do you take Cortisone medication? ◯ Yes ◯ No

Have you reacted adversely to codeine, nitrous oxide or local anesthetics? _____

Are you sensitive to metals or latex? _____

Are you pregnant or suspect you may be? ◯ Yes ◯ No

Do you use any birth control medications? ◯ Yes ◯ No

Do you have a pacemaker or an artificial heart valve implant? Other heart disease? _____

Have you ever had rheumatic fever? ◯ Yes ◯ No

Are you aware of any heart murmurs? ◯ Yes ◯ No

Have you ever had Redux or Phen Fen? Bisphosphonates? ◯ Yes ◯ No

Do you have any artificial joints/prothesis? _____

Do you have Glaucoma? ◯ Yes ◯ No

Do you have sleep apnea? If so, do you use a CPAP? _____

Have you had a serious illness or major surgery in the last 5 years?

_____

_____

Have you ever had radiation treatment or chemo? ◯ Yes ◯ No

Do you have immune system inflammatory diseases, such as arthritis or rheumatism? ◯ Yes ◯ No

Do you have high or low blood pressure? _____

Have you ever bled excessively after being injured or have any other blood disorders? ◯ Yes ◯ No

Do you have Hemophilia or Anemia? _____

Do you have any kidney or liver problems? ◯ Yes ◯ No

Do you have diabetes? If so, insulin or diet controlled? Last A1C _____

Do you have asthma? ◯ Yes ◯ No

Do you have epilepsy or seizure disorders? ◯ Yes ◯ No

Have you tested postitive for HIV or do you have AIDS? ◯ Yes ◯ No

Have you had or do you test positive for hepatitis? ◯ Yes ◯ No

Do you have or have you had Tuberculosis? ◯ Yes ◯ No

Do you smoke, or use any forms of tobacco? Do you use controlled substances? _____

Do you have any other conditions not listed or is there anything else we should know?

_____

_____

☐ **I certify that the above information is complete and accurate.**

Response Date: _____