MEDICAL HISTORY

Last Name: ____________ First Name: ____________ Birth-date: ____________

Name of Medical Doctor: ____________ City/State: ____________

Emergency Contact: ____________ Phone: ____________ Relationship: ____________

List all medications that you are now taking:

1. ____________
2. ____________
3. ____________
4. ____________
5. ____________
6. ____________
7. ____________
8. ____________
9. ____________
10. ____________

Are you allergic to any of the following?

Y	N	
☐	☐	Acrylic
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetic
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Sulfa

Other allergies not listed above:

____

Do you have any of the following medical conditions?

Y	N	
☐	☐	Anaphylaxis
☐	☐	Artificial Heart Valve
☐	☐	Artificial Joint
☐	☐	Asthma
☐	☐	Cancer
☐	☐	Cold Sores/Fever Blisters
☐	☐	Congenital Heart Disorder
☐	☐	Diabetes
☐	☐	Epilepsy or Seizures
☐	☐	Glaucoma
☐	☐	Heart Disease/Attack (Angina)
☐	☐	Heart Murmur
☐	☐	Heart Pacemaker
☐	☐	Hepatitis A, B, or C
☐	☐	High Blood Pressure
☐	☐	Stroke

Other conditions not listed above:

____

Tobacco use? If so, what kind and how much? ____________

Recently hospitalized or had a major operation? ____________

Currently taking or have taken, Phen-Fen or Redux? ____________

Currently taking or have taken, Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?

____

Women Only:

Pregnant, nursing, or planning on becoming pregnant? ____________

Currently taking birth control pills? ____________

Additional Comments:

Patient/Guardian Signature: ____________

Date: ____________