Medical History Co...nued

Have you ever taken Phen-Fen? (Also known as Redux or Pondimin) Yes No If so when? ________________

Have you ever had any of the following diseases or medical problems? Please circle Y or N.

Y N Abnormal Bleeding
Y N Alcohol/Drug Abuse
Y N Anemia
Y N Arthritis
Y N Artificial/Joints/Valves
Y N Asthma
Y N Blood Transfusion
Y N Cancer/Chemotherapy
Y N Chronic Cough
Y N Colitis
Y N Diabetes
Y N Difficulty Breathing
Y N Emphysema
Y N Epilepsy/Seizures
Y N Frequent Headaches
Y N Glaucoma
Y N GERD Disease
Y N Hay Fever
Y N Heart Attack
Y N Heart Murmur
Y N Heart Surgery
Y N Hemophilia
Y N Hepatitis A,B or C
Y N Herpes/Fever Blisters/Cold Sores
Y N High Blood Pressure
Y N High Cholesterol
Y N HIV/AIDS Positive
Y N Kidney problems/Stones
Y N Liver Disease
Y N Low Blood Pressure
Y N Lupus
Y N Macular Degeneration
Y N Mitral Valve Prolapse
Y N Pacemaker/Defibrillator
Y N Psychiatric Care
Y N Radiation treatment
Y N Rheumatic Fever
Y N Scarlet Fever
Y N Shingles
Y N Snoring/Sleep Apnea
Y N Sinus Problems
Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis
Y N Ulcers
Y N Venereal Disease

Please list any other serious medical condition(s) that you have or ever had________________

____

Have you ever taken oral Bisphosphonates for Osteoporosis, Multiple Myeloma, Metastatic Cancer or Paget's disease? Yes No

Have you ever had Facial Cosmetic surgery? Yes No

Are you allergic to any of the following? Sulfa Y N

Aspirin	Y N	Erythromycin	Y N
Codeine	Y N	Latex	Y N
Dental Anesthetic	Y N	Penicillin	Y N
Cosmetics	Y N	Tetracycline	Y N

Dental History

Why have you come to the Dentist today?

____

Do you require antibiotics before dental treatments? Y N

Have you ever been diagnosed with periodontal disease?

Y N If yes when was your last Perio Treatment done?

____

Are you happy with the color of your teeth? Y N

Are you happy with your smile Y N

If NO what would you like to change about your smile?

____

Medical History

Do you have a personal physician? Yes No

Physician's Name________________

Phone#(______)________________

Are you currently under the care of a physician? Yes No Please Explain________________

____

Do you smoke or use tobacco in any form?

Yes No What type of tobacco? __________

Have you had any metal rods, pins or implants?

Yes No Where?________________

Are you taking any prescription/over the counter or herbal supplements? Yes No

Please List________________

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Medical History Update (Office Use Only)

I have read my medical history dated________and confirm that there are no changes in my medical History________________
Signature Date

I have read my medical history dated________and confirm that there are no changes in my medical History________________
Signature Date

I have read my medical history dated________and confirm that there are no changes in my medical History________________
Signature Date