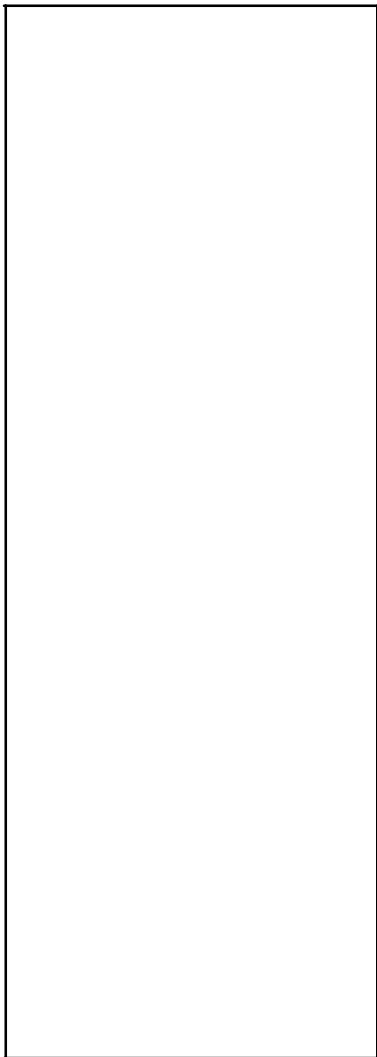


Medical History

Last name: (print) _____ First name: _____ Date: _____
 Nickname: _____ MI: _____ Title: Mr. Mrs. Miss Ms. Dr.
 Date of birth: _____ Marital status: Married Single Widowed Divorced
 Street: _____ City: _____ Zip code: _____
 Social Security #: _____ Email: _____
 Home phone: _____ Employed by: _____ Business phone: _____
 Cell phone: _____ Spouse's name: _____ Spouse's work phone: _____
 Dental Insurance Co: _____ Insured/Policyholder SSN: _____ Insured date of birth: _____
 Referred by: _____ Closest Relative: _____

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Are you under a physician's care at present?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have any type of health problem?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, if yes please specify | | |
| _____ | | |
| _____ | | |
| 3. Are you taking any medicine or vitamins now?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please specify names(s) | | |
| _____ | | |
| _____ | | |
| 4. Have you ever been seriously ill?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any of the following? | | |
| A heart valve replacement..... | <input type="checkbox"/> | <input type="checkbox"/> |
| A history of infective endocarditis (IE) | <input type="checkbox"/> | <input type="checkbox"/> |
| A serious congenital heart condition | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart trouble..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| Positive HIV or AIDS..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Artificial implants (joints, hip, knee, etc.)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Hepatitis/Liver problem..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever had an allergic reaction to any of the following? | | |
| Latex..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Household Cleaners..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Perfumes, clove oil, eugenol..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Penicillin/Antibiotics..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Aspirin | <input type="checkbox"/> | <input type="checkbox"/> |
| Other medicine: _____ | | |



(over)

- | | Yes | No |
|--|--------------------------|--------------------------|
| 7. Have you ever experienced an unusual reaction to a dental injection (novocaine / lidocaine)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever had an injury to your face or jaws? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever had surgery for a tumor or growth?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you ever had radiation treatment?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Are you short of breath on mild exertion or have asthma?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you have chest pain on exertion?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do your ankles swell or have pulmonary edema?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you ever had prolonged bleeding following a cut or extraction of a tooth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. How many times per week do you drink alcohol? _____ | | |
| 16. Do you have any disease, condition or problem not listed above that you think I should know about? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please specify _____ | | |
| _____ | | |

Women only

- | | | |
|---|--------------------------|--------------------------|
| 17. Do you have osteoporosis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Are you pregnant or potentially pregnant?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Are you currently taking any birth control medication?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, Antibiotics may reduce the effectiveness of birth control medication. | | |
| 20. Do you take Fosamax, Boniva, or other anti-osteoporosis medication? | <input type="checkbox"/> | <input type="checkbox"/> |

Physician (Medical doctor)

Name: _____

Address: _____

Signature: (patient or patient's representative)