MEDICAL HISTORY

Physician's Name: _____Date of Last Visit: _____

Have you ever been told by a physician or dentist that you should pre-medicated with an antibiotic prior to dental visits? yes/no

1. Are you currently being treated for a medical condition? yes/no
2. Have you ever had any serious illnesses or operations? yes/no
3. Are you currently taking any medications? yes/no
   Are you currently taking the medication Fosamax Or other biophosphonate? yes/no
   Have you taken Fosamax in the past? yes/no
   Please list all medications: _____
   _____
4. Do you take aspirin? yes/no
5. Do you smoke? yes/no
   Quantity/Frequency? _____
6. Do you use chewing tobacco? yes/no
   Quantity/Frequency? _____
7. Do you use alcohol? yes/no
   Quantity/Frequency? _____
8. Do you use cocaine or other drugs? yes/no
   Quantity/Frequency? _____
9. Do you wear contact lenses? Yes/no
10. Have you had any allergic reactions to the following:

Local Anesthetics (i.e. novacaine)	yes/no
Penicillin or other Antibiotics	yes/no
Sulfa Drugs	yes/no
Latex	yes/no
Barbiturates (codeine)	yes/no
Sedatives (valium)	yes/no
Iodine	yes/no
Aspirin	yes/no
Nickel or other metals	yes/no
Other: _____	yes/no

11. (Women Only) Are you:

Pregnant?	yes/no
Nursing?	yes/no
Taking birth control pills?	yes/no
Hormone Replacement Therapy?	yes/no

12. Have you ever taken Phen Phen? yes/no
13. Do you take herbal supplements? yes/no

Please circle all that apply:

Aids/HIV	yes/no	Fainting	yes/no	Nervous Disorders	yes/no
Allergies	yes/no	Glaucoma	yes/no	Pacemaker	yes/no
_____		Hay Fever	yes/no	Radiation Treatment	yes/no
_____		Head Injuries	yes/no	Respiratory Problems	yes/no
Arthritis	yes/no	Heart Disease	yes/no	Rheumatic Fever	yes/no
Artificial Joints	yes/no	Heart Murmur	yes/no	Sinus Problems	yes/no
Asthma	yes/no	Hepatitis	yes/no	Stomach Problems	yes/no
Blood Disease	yes/no	High Blood Pressure	yes/no	Stroke	yes/no
				Thyriod trouble	yes/no
Cancer	yes/no	Jaundice	yes/no	Tuberculosis	yes/no
Diabetes	yes/no	Kidney Disease	yes/no	Tumors	yes/no
Dizziness	yes/no	Liver Disease	yes/no	Ulcers	yes/no
Epilepsy	yes/no	Mental Disorders	yes/no	Venereal Disease	yes/no
Excessive Bleeding	yes/no	Mitral Valve Prolapse	yes/no	Other: _____	yes/no

DENTAL HISTORY

Former Dentist: _____

City, State: _____ Phone:_____

Date of Last Dental Visit: _____

Do you need antibiotic pre-medication for dental treatment? Yes/no

Date of Last X-rays? _____

How often Do You Floss? _____

How Often Do You Brush? _____

What was usually prescribed? _____

Please check all that apply:

Fingernail biting	yes/no	Clench/Grind Teeth	yes/no	Sensitivity when biting	yes/no
Lip or cheek biting	yes/no	Orthodontic Treatment	yes/no	Tooth pain	yes/no
Dental fears	yes/no	Frequent headaches	yes/no	Bad breath	yes/no
Unfavorable dental experiences	yes/no	Jaw clicking or pain	yes/no	Bleeding gums	yes/no
Blisters on lip or mouth	yes/no	Sensitivity to cold	yes/no	Loose teeth	yes/no
Pain around ear	yes/no	Sensitivity to heat	yes/no	Periodontal treatment	yes/no
Jaw, Head or Neck injuries	yes/no	Sensitivity to sweets	yes/no	Broken fillings	yes/no
Dry mouth, throat and/or eyes	yes/no				

Unhappy with the appearance of your teeth?	yes/no	Do new people/places make you anxious?	yes/no
Unhappy with the color of your teeth?	yes/no	Do you sweat or tremble during dental exams?	yes/no
Unhappy with the size/shape/position of your teeth?	yes/no	Awaken with an awareness of your teeth or jaws?	yes/no
Problems with effectiveness or bad reaction to dental anesthetic?	Yes/no		