Medical History

	Y	N	If yes, please elaborate:
Are you currently under a physician's care?			
Have you been hospitalized/had a surgery?			
Have you ever had a head or neck injury?			
Are you taking any medications, pills, drugs?			
Have you ever taken Phen-Fen or Redux?			
Have you ever taken Boniva, Fosamax, Actonel, or meds with bisphosphonates?			
Are you on a special diet?			
Do you use tobacco?			
Do you use controlled substances?			

Are you allergic to any of the following:
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics
☐ Other:

Women, are you: ☐ Pregnant/Trying to Get Pregnant? ☐ Nursing? ☐ Taking Oral Contraceptives?

Have you ever had the following?	Y	N		Y	N		Y	N		Y	N
AIDS/HIV Positive			Cortisone Medicine			Hemophilia			Radiation Treatment		
Alzheimer's			Diabetes			Hepatitis A			Recent Weight Loss		
Anaphylaxis			Drug Addiction			Hepatitis B or C			Renal Dialysis		
Anemia			Easily Winded			Herpes			Rheumatic Fever		
Angina			Emphysema			High Blood Pressure			Rheumatism		
Arthritis/Gout			Epilepsy or Seizures			High Cholesterol			Scarlet Fever		
Artificial Heart Valve			Excessive Bleeding			Hives or Rash			Shingles		
Artificial Joint			Excessive Thirst			Hypoglycemia			Sickle Cell Disease		
Asthma			Fainting/Dizziness			Irregular Heartbeat			Sinus Trouble		
Blood Disease			Frequent Cough			Kidney Problems			Spina Bifida		
Blood Transfusion			Frequent Diarrhea			Leukemia			Stomach/Intestinal Disease		
Breathing Problems			Frequent Headaches			Liver Disease			Stroke		
Bruise Easily			Genital Herpes			Low Blood Pressure			Swelling of Limbs		
Cancer			Glaucoma			Lung Disease			Thyroid Disease		
Chemotherapy			Hay Fever			Mitral Valve Prolapse			Tonsillitis		
Chest Pains			Heart Attack/Failure			Osteoporosis			Tuberculosis		
Cold Sores/Fever Blisters			Heart Murmur			Pain in Jaw Joints			Tumors or Growths		
Congenital Heart Disorder			Heart Pacemaker			Parathyroid Disease			Ulcers		
Convulsions			Heart Disease			Psychiatric Care			Venereal Disease		
									Yellow Jaundice		

Have you had any serious illness not listed above? ☐ No ☐ Yes (If yes, please elaborate):

Comments:

To the best of my knowledge, this form has been accurately completed. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the office of any medical changes.

Printed Name: Signature: Date: