MEDICAL HISTORY

We appreciate the confidence you place with us to provide dental services. Assist us in serving you by completing the following form. In the future, notify us of any changes in your health.

Patient Name: ________________ Date of Birth: ____/____/____ Age ______

Primary M.D.: ________________ Mailing Address ________________ Phone (____)________

Secondary M.D.: ________________ Mailing Address ________________ Phone (____)________

Previous dentist: ________________ Last dental visit: ____/____/____ Last medical exam: ____/____/____

PLEASE CIRCLE "YES" OR "NO" ON EACH OF THE FOLLOWING

Cardiovascular Problems

- Artificial heart valve ________ Yes No
- History of infective endocarditis ________ Yes No
- Certain specific, serious, congenital heart conditions:
  - Cyanotic congenital heart disease: Unrepaired or incompletely repaired (shunts and conduits?) __ Yes No
  - Completely repaired congenital heart defect with prosthetic material or device (less than six months) Yes No
  - Repaired congenital heart defect with residual defect at or adjacent to the site of prosthetic patch/device Yes No
- Cardiac transplants that develop valve problems __ Yes No
- Arteriosclerosis ________ Yes No
- Blood pressure problem ________ Yes No
  - Usual Blood Pressure: _____/____
- Chest pain upon exertion ________ Yes No
- Congenital heart malformations ________ Yes No
- Coronary occlusion or insufficiency ________ Yes No
- Heart attack ________ Yes No
- Heart murmur ________ Yes No
- Heart surgery ________ Yes No
- Hypertrophic cardiomyopathy ________ Yes No
- Mitral valve prolapse with valvular regurgitation __ Yes No
- Pacemaker ________ Yes No
- Rheumatic or other acquired heart valve problems _ Yes No
- Stroke ________ Yes No

Blood Problems

- Abnormal bleeding history ________ Yes No
- Blood disease (anemia) ________ Yes No

Liver Problems

- Hepatitis ________ Yes No

Kidney Problems ________ Yes No

Allergy problems ________ Yes No

Respiratory

- Asthma, Emphysema ________ Yes No
- Tuberculosis ________ Yes No

Bone or Joint Problems

- Arthritis ________ Yes No
- Joint replacement ________ Yes No

Neurological

- Seizures or Epilepsy ________ Yes No

Diabetes ________ Yes No

Cancer/Tumor (Past or Present) ________ Yes No

- Radiation: Head/Neck Region (Past or Present) __ Yes No
- Chemotherapy: (Past or Present) ________ Yes No

Herpes, Venereal Disease, HIV+, AIDS ________ Yes No

Alcoholism ________ Yes No

Tobacco

- Do you smoke or chew tobacco? ________ Yes No
- How much? ________

Are you allergic to or have you reacted adversely to any of the following:

- Codeine, barbiturates, sedatives, sleeping pills ____ Yes No
- Latex ________ Yes No
- Local anesthetics ("Novocain") ________ Yes No
- Penicillin or other antibiotics ________ Yes No
- Other ________

Are you taking any of the following:

- Antibiotics or sulfa drugs ________ Yes No
- Anticoagulants (blood thinners), aspirin ________ Yes No
- Antidepressants ________ Yes No
- Cortisone (steroids) ________ Yes No
- Digitalis, Nitroglycerin, or drugs for heart trouble _ Yes No
- High blood pressure medicine ________ Yes No
- Insulin, Orinase, or similar drug ________ Yes No
- Tranquilizers ________ Yes No
- Other ________

Are you taking, or have you ever taken bisphosphonates for chemotherapy or osteoporosis:

- Actonel, Boniva, Fosamax, IV Aredia, IV Zometa _ Yes No

Women

- Are you taking contraceptives or other hormones? _ Yes No
- Are you pregnant? ________ Yes No
  - If so, expected delivery date: ____/____/____

Do you have any diseases or conditions not listed above? If so, please explain: ________________

Have your ever had adverse reactions with dental treatment? If so, please explain: ________________

To the best of my knowledge, all of the preceding answers are true and correct. If I have any change in my health or medications, I will inform the doctor at future appointments. I grant permission for my physician to be contacted for details and advice. I further authorize the taking of radiographs, photographs, or other diagnostic measures appropriate for a thorough evaluation. Authorizations is also given for dental treatment to be rendered by the dentist and office staff.

________________ ____/____/____

Signature: Patient / Parent / Guardian

________________ ____/____/____

Signature: Patient / Parent / Guardian

Dr. Homer Initials: ________ ____/____/____