

## Medical & Dental History Form

Are you currently taking any medications?  
(Including any medication for osteopenia or osteoporosis, such as Actonel, Boniva, Fosamax)

Yes  No

If Yes, please list:

Are you allergic to any medications (including LATEX)?

Yes  No

If Yes, please list:

Please indicate if you have experienced any of the following:

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Artificial Joints   | <input type="checkbox"/> Asthma             | <input type="checkbox"/> Cancer          | <input type="checkbox"/> Diabetes      |
| <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Glaucoma        | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Heart Pacemaker    | <input type="checkbox"/> Heart Surgery   | <input type="checkbox"/> Hepatitis     |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> HIV positive/AIDS  | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Tuberculosis  |

WOMEN ONLY: Are you pregnant?

Yes  No

Your Primary Care Physician's Name and/or Name of Clinic, and city

If you have any other health concerns we need to know or you are currently under the care of a physician for a specific condition not listed, please explain:

Have you ever been told to take an antibiotic or premedication prior to dental treatment?

Yes  No

Response Date: