Medical History Update

Name____Date of Birth________________________

Name of personal physician:_____________________________________Phone:________________

Date of last visit:____

Have you had any health problems in the last year? YES or NO (circle)

If yes, please explain:____

____

Women–a. are you currently pregnant? YES or NO If yes, how many months? ___________________

b. Are you taking any form of bisphosphonates (i.e.: Fosamax, Boniva) YES or NO

Please circle if you are allergic to any of the following:

Local anesthetics | Sulfa Drugs | Codeine/other narcotics | Other:__________________

Penicillin/other | Aspirin | Latex Sensitivity

Do you have, or have you had, any of the following? (please circle)

Artificial Heart Valve | Heart Pacemaker

Artificial Joint | Mitral Valve Prolapse

Heart Murmur | Rheumatic Fever

Do you have, or have you had, any of the following? (please circle)

Acid Reflux
Alzheimer's Disease
Arthritis
Asthma
Blood Transfusion
Cancer
Chemotherapy
Chest Pains
Cold Sores/Fever Blisters

Congenital Heart Disorder
Diabetes
Epilepsy or Seizures
Heart Attack/Failure
Heart Trouble/Disease
Hemophilia
High Blood Pressure
History of Tobacco Use
Hypoglycemia

Pain in jaw joints
Radiation
Stomach/Intestinal Disease
Stroke
Thyroid Disease
Tuberculosis
Tumors or Growths
Ulcers

Please list any prescription medications you are taking:____________________________

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Signature:____Date:____________________