Patient Medical History

----------Do you or have you had any of the following:----------	Yes	No
1.) High Blood Pressure or Low Blood Pressure (circle one)		
2.) Heart Attack When?-		
3.) Cardiac Pacemaker		
4.) Chest Pains or Angina		
5.) Heart Murmur		
6.) Heart Disease		
7.) Stroke		
8.) Fainting Spells, Seizures, or Convulsions		
9.) Rheumatic Fever		
10.) Asthma		
11.) Emphysema		
12.) Easily Winded		
13.) Tuberculosis		
14.) Respiratory Problems		
15.) Liver Disease		
16.) Hepatitis or Jaundice		
17.) Kidney Diseases		
18.) Leukemia		
19.) Diabetes		
20.) Thyroid Problems		
21.) Cancer What type?-		
22.) Radiation Treatment		
23.) AIDS or HIV Infection		
24.) Sexually Transmitted Disease		
25.) Anemia		
26.) Stomach Ulcers		
27.) Recent Weight Loss		
28.) Glaucoma		
29.) Have You Ever Taken Fen-Phen or Redux?		
30.) Have You Ever Taken A Bisphosphonate, Such As Boniva or Fosamax?		
31.) Do You Use Tobacco Products? # of Packs Per Week-		
32.) Do You Use Alcohol, Cocaine, Or Other Recreational Drugs?		
33.) Do You Have Any Artificial Joints?		
34.) Are You Pregnant Or Nursing?		

Are You Currently Under Medical Treatment? No - Yes, for_____

Have You Been Hospitalized In The Last Year? No - Yes, for_____

Are You Allergic To Any Medications, Dyes, or Latex? No - Yes, _____

Please List Any Medications You Are Taking, Including Non-Prescription Supplements: _____

_____

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What Brings You In To See Us Today? _____

Approximately When Was The Last Time You Saw A Dentist? _____