COMPREHENSIVE MEDICAL HISTORY

Name (Mr. Mrs. Ms. Dr)__________________________ Birth Date:____________
Home Address: ____________________ City:________ Postal Code:__________
Home# ________ Cell#________ Work#________ E-Mail Address ____________
Employer________ Spouse's Name __________ Spouse's Employer__________
Do you have Dental Insurance? Yes No

MEDICAL: Doctor's Name: ____________ Address ________ Phone__________

Are you under a physician's care now? Yes No If yes, please explain: __________
Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: __________
Have you ever had a serious head, back or neck injury? Yes No If yes, please explain: __________
Do you take, or have you taken, Phen-Fen or Redux? Yes No
Are you on a special diet? Yes No
Do you use tobacco? Yes No
Do you use controlled substances? Yes No
Do you have osteoporosis or other bone condition? Yes No
Do you or have you ever required premedication for dental appointments? Yes No

Women: Are you:
Pregnant/Trying to get pregnant? Yes No
Nursing? Yes No
Taking oral contraceptives? Yes No

Are you ALLERGIC to any of the following? (Please Circle)
Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
Other Allergies & Explanations: __________________________

Do you have, or have a recent history, of any of the following? (Please Circle)

AIDS/HIV Positive	Chest Pains	Frequent Headaches	Irregular Heartbeat	Alzheimer's Disease
Cold Sores/Fever Blisters	Kidney Problems	Shingles	Anaphylaxis	Congenital Heart Disorder
Leukemia	Hypoglycemia	Anemia	Jaundice	Liver Disease
Sinus Trouble	Angina	Cortisone Medicine	Heart Attack/Failure	High Blood Pressure
Arthritis/Rheumatism	Diabetes Type I or II	Heart Murmur	Lung Disease	Artificial Heart Valve
Drug Addiction	Heart Pace Maker	Mitral Valve Prolapse	Stroke	Easily Wind
Heart Trouble/Disease	Swelling of Limbs	Asthma	Emphysema	Hemophilia
Thyroid Disease	Blood Disease	Epilepsy or Seizures	Hepatitis A	Hepatitis B OR C
Psychiatric Care	Blood Transfusion	Excessive Bleeding	Radiation Treatments	Tuberculosis
Breathing Problems	Excessive Thirst	Recent Weight Loss	Tumors or Growths	Bruise Easily
Fainting Spells/Dizziness	Renal Dialysis	Ulcers	Cancer	Chemotherapy
Frequent Cough	Hives/Rash	Rheumatic Fever	Artificial Joint/Pins/Plates	
Pain/Popping/Clicking Jaw				

Have you ever taken any of the ***bisphoshonates***, such as Boniva, Areida, Fosamax, Bondronat, Actonel or Zonmeta? Yes No If so, how long have you been taking? ____________

ARE YOU TAKING ANY PRESCRIBED MEDICATIONS? If so please list:

NAME	DOSE	TIME TAKEN

LIST ALL VITAMINS, HERBS, HOMEOPATHICS ETC & DOSAGE: __________________

History of past treatment of Orthodontics or Periodontal Disease/Conditions? Date __________
Name of previous Dentist? ____________ How long since your last visit? ________
If you could change anything about your teeth what would it be? ____________
Who may we thank for referring you to our office? ____________

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AT THIS TIME.

Today's Date:____________ Signature____________