

MEDICAL HISTORY

FIRST NAME: LA	ST NAME:
Your Cu	RRENT PHYSICAL HEALTH IS:
Go	OOD FAIR POOR
ARE YOU CURRENTLY UNDER THE CARE OF A	
PHYSICIAN? YES NO	To THE BEST OF YOUR KNOWLEDGE, ARE YOU O
IF SO, PLEASE SPECIFY?	HAVE YOU EVER BEEN AFFLICTED WITH THESE:
	JOINT REPLACEMENTS YES NO
	DO YOU OR DID YOU EVER
	TAKE ACTONEL, FOSAMAX? YES NO
	RHEUMATIC FEVER YES NO
FAMILY PHYSICIAN'S NAME	EPILEPSY YES NO
	HIGH BLOOD PRESSURE YES NO
	RESPIRATORY DISEASE YES NO
PHYSICIAN'S PHONE ARE YOU TAKING ANY DRUGS OR MEDICATIONS? YES NO	HEPATITIS YES NO
	PROLONGED BLEEDING YES NO
	HEALING COMPLICATIONS YES NO
	TEAR MEMERIS
	O PACEMAKER YES NO
IF So, PLEASE LIST EACH ONE OR ATTACH A LIST	DIABETES YES NO
	CANCER YES NO
	Do You Have Any Known Allergies?
	IF SO, PLEASE LIST EACH ONE: YES NO
	ARE YOU ALLERGIC TO ANY MEDICATIONS? IF SO, PLEASE LIST EACH ONE: YES NO
	DO YOU NEED TO PRE-MEDICATE WITH ANTIBIOTIC
	FOR DENTAL PROCEDURES? YES NO
	FOR WOMEN: ARE YOU TAKING BIRTH CONTROL? YES NO
	Are You Pregnant? YES NO
	ARE YOU NURSING? YES NO
ERSON TO CONTACT IN CASE OF AN OF EMERGE	NCY: PHONE:
	AND ANESTHETICS ARE NECESSARY FOR THE TREATMENT FOR EE TO ASSUME FULL FINANCIAL RESPONSIBILITY FOR ALL
ATIENT SIGNATURE (OR LEGAL GUARDIAN)	DATE