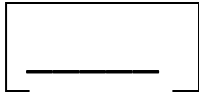


Medical History:



Office use

Medications currently taking: None Insulin Blood Thinners (including aspirin) Muscle relaxers Pain Killer

Have you ever taken: Osteoporosis Meds (ex. Aredia/Fosamax) Yes No

Surgery and Medical Conditions: None _____

Have you ever had a Prosthetic repair to your heart Yes No

- | | | |
|--|--|--|
| <input type="checkbox"/> Heart Attack/Stroke | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Heart Surg./Pacemaker | <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Jaw Problems |
| <input type="checkbox"/> Artificial Valves | <input type="checkbox"/> Arthritis/ Rheumatism | <input type="checkbox"/> Severe Frequent Headaches |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Drug Abuse |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Seizures/ Epilepsy |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> HIV+/AIDS/ARC |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Psychiatric diagnosis |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Tuberculosis | |

Allergies: None Latex Penicillin / Amoxicillin Tetracycline Seasonal Food _____

Do you use tobacco Yes No Type _____

Dental Information:

Times a day you brush? _____ Floss _____ Mouth wash _____

What type of tooth brush do you use? _____

Last Dental Exam ____/____/____ Last Dental X-rays ____/____/____

Medical Dr. _____ Medical Specialist _____

Phone # _____ Phone # _____

Emergency Contact _____ Phone # _____

For Women:

Are you pregnant? Yes No duration _____ nursing Yes No

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ____/____/____