MEDICAL HISTORY

Name:_____ Date:_____

Do you, or have you had any of the following? Circle Yes or No next to each item:

YES NO	Heart Condition	YES NO	Bisphosphonate Therapy
YES NO	High Blood Pressure	YES NO	Arthritis
YES NO	Bleeding problem	YES NO	Artificial Joint/Device
YES NO	Blood Transfusion	YES NO	Cancer
YES NO	High Cholesterol	YES NO	Chemotherapy/Radiation
YES NO	Lung/Breathing Problem	YES NO	Tumor/Growth
YES NO	Tuberculosis	YES NO	Thyroid Problem
YES NO	Sinus Problem	YES NO	Glaucoma
YES NO	Sleep Apnea	YES NO	HIV/AIDS
YES NO	Diabetes	YES NO	Oral Herpes/Cold Sores
YES NO	Liver Disease/Hepatitis	YES NO	Hearing Impairment
YES NO	Stomach/Digestive Problem	YES NO	Jaw Joint Problem
YES NO	Acid Reflux	YES NO	Migraines/Headaches
YES NO	Kidney Disease	YES NO	Drug Abuse/Treatment
YES NO	Autoimmune Disease	YES NO	Tobacco Use/History
YES NO	Neurological Problem	YES NO	Recent Weight Fluctuation
YES NO	Epilepsy/Seizures	YES NO	Women: Pregnant/Nursing
YES NO	Psychiatric Treatment	YES NO	Condition not listed
YES NO	Depression		
YES NO	Alcohol Abuse/Treatment		
YES NO	Stroke		
YES NO	Osteoporosis/Osteopenia		

_____
_____
_____
_____
_____
_____
_____
_____

Allergies or Adverse Responses:

_____
_____
_____
_____
_____

Current Medications and Vitamins:

_____
_____
_____
_____

Have you been in the care of a physician in the past 2 years? If yes, please explain:_____

_____

Have you been hospitalized or had surgery in the past 5 years? If yes, please explain:_____

_____

Name of Physician(s)/Specialist(s), including location and phone numbers:_____

_____

I hereby certify that I have read and understand each question and have answered to the best of my ability:

_____

SIGNATURE OF PATIENT OR PARENT IF MINOR DATE

Oceanspray Dental Health
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