MEDICAL HISTORY

Name: _____
First Middle Initial Last

1. Are you having tooth pain or discomfort at this time? Yes No
2. Have you been under the care of a medical doctor during the past two years? Yes No
3. If you have been under the care of a doctor, what condition(s) was treated or is currently being treated?
   _____
   _____
   i. Physician's Name: _____
   ii. Physician's Phone Number: _____
4. Are you now taking any medications or drugs? Yes No
   a. If so, what medications or drugs are you taking?
   _____
5. Are you taking or have you taken Fosamax or other medication for bone conditions? Yes No
   a. If so, what medications or drugs are you taking?
   _____
6. Are you sensitive or allergic to any medications or drugs? Yes No
   a. If so, what medications or drugs are you sensitive or allergic to?
   _____
7. When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? Yes No
8. Have you lost or gained more than 10 pounds in the past year? Yes No
9. Do you ever wake up from sleep and feel short of breath? Yes No
10. Have you ever had any history of TMJ (jaw joint) disorders or pain? Yes No

Please check any of the following you have had or presently have:

Heart Failure	yes	no	Artificial Joint (hip, knee)	yes	no	Allergic to Latex	yes	no	Stroke	yes	no
Heart Disease or Attack	yes	no	Kidney Trouble	yes	no	Hepatitis B (serum)	yes	no	Ulcers	yes	no
Angina Pectoris	yes	no	Diabetes	yes	no	Venereal Disease	yes	no	Hepatitis A (infectious)	yes	no
Congenital Heart Disease	yes	no	Thyroid Problems	yes	no	AIDS	yes	no	Hemophilia	yes	no
Heart Murmur	yes	no	Sinus Trouble	yes	no	HIV Positive	yes	no	Drug Addiction	yes	no
High Blood Pressure	yes	no	Cancer	yes	no	Cold Sores/Fever Blisters	yes	no	Chemotherapy	yes	no
Arteriosclerosis	yes	no	Emphysema	yes	no	Blood Transfusion	yes	no	Allergy to Shellfish	yes	no
Mitral Valve Prolapse	yes	no	Chronic Cough	yes	no	Anemia	yes	no	Cortisone Medicine	yes	no
Artificial Heart Valve	yes	no	Tuberculosis	yes	no	Sickle Cell Anemia	yes	no	Radiation Therapy	yes	no
Heart Pacemaker	yes	no	Asthma	yes	no	Bruise Easily	yes	no	Rheumatism	yes	no
Heart Surgery	yes	no	Arthritis	yes	no	Liver Disease	yes	no	Fainting or Dizziness	yes	no
Rheumatic Fever	yes	no	Allergies or Hives	yes	no	Yellow Jaundice	yes	no	Allergy to Iodine	yes	no
TMJ	yes	no	Epilepsy or Seizures	yes	no	Developmentally Disabled	yes	no			

11. Do you have or have you had any disease, condition or problem not listed? Yes No
    If yes, please list: _____
12. Your Pharmacy name: _____ Phone Number: _____

For Women Only

13. Are you pregnant? Yes No
    a. If yes, how many month? _____
14. Are you nursing? Yes No
15. Are you taking birth control pills? Yes No