



## Patient's Medical History Information

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Why have you come to the dentist today? \_\_\_\_\_

Last visit to the dentist \_\_\_\_\_ Who was your previous dentist? \_\_\_\_\_

Do you have a physician? Yes \_\_\_\_ No \_\_\_\_

May we have permission to contact your physician if necessary? Yes \_\_\_\_ No \_\_\_\_

Physician's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Are you currently under the care of a physician? Yes \_\_\_\_ No \_\_\_\_ If yes, explain \_\_\_\_\_

Please list all medications you are currently taking \_\_\_\_\_

For females – Are you pregnant? Yes \_\_\_\_ No \_\_\_\_ Week # \_\_\_\_\_

OB/GYN's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Have you had any serious medical problems in the past 5 years? Yes \_\_\_\_ No \_\_\_\_

Please explain \_\_\_\_\_

Are you **ALLERGIC** to any of the following? **PLEASE CIRCLE**

Y	N	Penicillin / Amoxicillin	Y	N	Aspirin
Y	N	Erythromycin	Y	N	Tetracycline
Y	N	Sulfa Drugs	Y	N	Codeine
Y	N	Dental Anesthetics	Y	N	Latex
Y	N	Other			

Please list \_\_\_\_\_

Do you have any of the following disease or medical problems? **PLEASE CIRCLE**

Y	N	Heart Attack / Stroke	Y	N	Cancer / Chemotherapy
Y	N	Heart Murmur / Rheumatic Fever	Y	N	HIV+ / AIDS
Y	N	Heart Surgery / Pace Maker	Y	N	Shingles
Y	N	Hepatitis	Y	N	Kidney Problems
Y	N	Anemia	Y	N	Sinus Problems
Y	N	High Blood Pressure	Y	N	Fever Blisters
Y	N	Low Blood Pressure	Y	N	Psychiatric Problems
Y	N	Epilepsy / Seizures / Fainting	Y	N	Diabetes
Y	N	Drug / Alcohol Abuse	Y	N	Tuberculosis TB
Y	N	Hemophilia / Abnormal Bleeding	Y	N	Sickle Cell Disease
Y	N	Severe Headaches	Y	N	Other

If yes on Other, please explain \_\_\_\_\_

## MEDICATION WARNING

Research has revealed that having certain dental procedures after taking Bisphosphonate drugs can result in severe side effects. The following drugs are commonly used to treat osteoporosis, certain types of cancer and other conditions that feature bone fragility. If you have ever been treated for any of these conditions but are not sure if you have ever taken any of the medications listed below, please let the doctor know.

Y	N	Actonel	Y	N	Zometa
Y	N	Aredia	Y	N	Bonefos
Y	N	Boniva	Y	N	Ostac
Y	N	Fosamax	Y	N	Skelid
Y	N	Didronel			

I the undersigned, do hereby authorize Morrison Dental Associates, PC to exam and treat the patient as deemed necessary by the dentist. If the undersigned is not the patient, he/she assumes all responsibility for the accurateness of the medical and dental information furnished on this form. I further affirm that the medical and dental information is correct and the patient does not have any communicable disease which would be infectious to those providing services for him/her or others coming in contact with the patient in the office. This authorization is good for two years.

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Patient or Guardian

Date