Time 1:11 PM | Mohr Smiles | Date 8/24/2023

Medical History 2023

Patient Name: | Birth Date: | Date Created:

History of bisphosphonate (Fosamax, Actonel, Atelvia, Boniva, Reclast, Prolia) for osteoporosis or Paget's disease? ◯ Yes ◯ No

History of IV (Aredia, Zometa, XGEVA) for hypercalcemia, Paget's disease, multiple myeloma or metastatic cancer? ◯ Yes ◯ No

Have you ever had radiation treatment to your head, neck, jaw or oral cavity? ◯ Yes ◯ No If yes

Do you use tobacco? ◯ Yes ◯ No

Have you ever been treated for cancer? ◯ Yes ◯ No If yes

Do you use Insulin? ◯ Yes ◯ No

Please list all medications in the box below

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Local Anesthetics
☐ Acrylic	☐ Clindamycin	☐ Tetracycline	☐ Metal

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Alzheimer's Disease/ Dementia	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Anemia	◯ Yes ◯ No
Angina/Chest Pains	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Artificial Heart Valve	◯ Yes ◯ No
GERD/ Acid Reflux	◯ Yes ◯ No	Artificial Joint	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No
Rheumatic Fever	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No
Sickle Cell Disease	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Chron's/Ulcerative Cholitis	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
High Cholesterol	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No
Irregular Heartbeat	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No	Kidney Disease	◯ Yes ◯ No
Emphysema/COPD	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No
Liver Disease	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No
Hepatitis A	◯ Yes ◯ No	Aneurysm	◯ Yes ◯ No	AFIB	◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

Comments: