Mohr Smiles Medical History Patient Name_____ Birth Date_____

History of bisphosphonate use/injection for osteoporosis or Paget's disease? ---------- ☐ Yes ☐ No
(Some examples are Boniva, Reclast, Prolia, Fosamax, Actonel, Atelvia)

History of IV infusion bisphosphonate treatment? ---------- ☐ Yes ☐ No
(Commonly for hypercalcemia (HCM), Paget's disease, multiple myeloma, other bone cancers)

Have you ever had radiation treatment to your head, neck, jaw, or oral cavity? ---------- ☐ Yes ☐ No

Do you currently use tobacco? ---------- ☐ Yes ☐ No

Are you currently being treated for cancer or receiving post cancer drug therapy? ---------- ☐ Yes ☐ No

Do you take insulin? ---------- ☐ Yes ☐ No

Are you currently taking a blood thinner? ---------- ☐ Yes ☐ No

Women, are you pregnant or trying to get pregnant? ---------- ☐ Yes ☐ No

Please list all current medications in the space below

Do you have allergies to any of the following:

☐ Tetracycline	☐ Aspirin /NSAIDS	☐ Codeine/Opioids	☐ Other_____
☐ Penicillin / Amoxicillin	☐ Tylenol/acetaminophen	☐ Metal	☐ Other_____
☐ Clindamycin	☐ Acrylic	☐ Local Anesthetics	☐ Other_____

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

AIDS/HIV	☐Yes ☐No	Stroke / TIA	☐Yes ☐No	Sickle Cell Disease	☐Yes ☐No
Infective Hepatitis (A,B,C)	☐Yes ☐No	Diabetes Type 1	☐Yes ☐No	Blood Clotting Disorder	☐Yes ☐No
Tuberculosis	☐Yes ☐No	Diabetes Type 2	☐Yes ☐No	Bleeding Disorder	☐Yes ☐No
Angina / Chest Pain	☐Yes ☐No	Hypoglycemia	☐Yes ☐No	Emphysema / COPD	☐Yes ☐No
Irregular Heart Beat	☐Yes ☐No	Thyroid Disease	☐Yes ☐No	Asthma	☐Yes ☐No
Rheumatic Heart Disease	☐Yes ☐No	Parathyroid Disease	☐Yes ☐No	Other Lung Disease	☐Yes ☐No
Infective Endocarditis	☐Yes ☐No	Liver Disease	☐Yes ☐No	Liver Disfunction	☐Yes ☐No
AFIB	☐Yes ☐No	Cortisone/Steroid Meds	☐Yes ☐No	Kidney Disfunction	☐Yes ☐No
Pacemaker	☐Yes ☐No	Leukemia	☐Yes ☐No	Renal Dialysis	☐Yes ☐No
Cardiac Stent	☐Yes ☐No	Auto-immune Disorder	☐Yes ☐No	Glaucoma	☐Yes ☐No
Artificial Heart Valve	☐Yes ☐No	Compromised Immunity	☐Yes ☐No	Artificial Joint	☐Yes ☐No
Congenital Heart Disorder	☐Yes ☐No	Cancer History	☐Yes ☐No	Epilepsy or Seizures	☐Yes ☐No
Heart Valve Defect	☐Yes ☐No	Anaphylaxis	☐Yes ☐No	Alzheimer's / Dementia	☐Yes ☐No
Mitral Valve Regurgitation	☐Yes ☐No	Osteoporosis / Osteopenia	☐Yes ☐No	Memory Loss	☐Yes ☐No
High Blood Pressure	☐Yes ☐No	Ulcerative Colitis	☐Yes ☐No	Fibromyalgia	☐Yes ☐No
Low Blood Pressure	☐Yes ☐No	Chron's Disease	☐Yes ☐No	Migraines	☐Yes ☐No
Heart Attack / Failure	☐Yes ☐No	GERD / Acid Reflux	☐Yes ☐No	Drug Addiction	☐Yes ☐No
Aneurism	☐Yes ☐No	Gastro-Intestinal Disease	☐Yes ☐No	Autism Spectrum Disorder	☐Yes ☐No
High Cholesterol	☐Yes ☐No	Anemia	☐Yes ☐No		

Have you 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 health and/or compromise treatment outcomes. It is my responsibility to inform my dentist of any changes in my medical status.

*Signature of Patient or Guardian*_____ *Date*_____

This space is for office use only.