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Medical History

continued

Your current physical health is:

Good Fair Poor

Do you smoke or use tobacco in any form? Yes No

Are you taking any prescription / over-the-counter or herbal supplement drugs? Yes No

Please list each one: _____

Have you ever taken Fosamax, or any other bisphosphonate? Yes No

Have you ever taken Phen-fen? Yes No

For Women: Are you using a prescribed method of birth control? Yes No

Are you pregnant? Yes No Week #: _____

Are you nursing? Yes No

Have you ever had any of the following diseases or medical problems?

- | | |
|--|---------------------------------|
| Y N Abnormal Bleeding | Y N Herpes / Fever Blisters |
| Y N Alcohol / Drug Abuse | Y N High Blood Pressure |
| Y N Anemia | Y N HIV+ / AIDS |
| Y N Arthritis | Y N Hospitalized for Any Reason |
| Y N Artificial Bones / Joints / Valves | Y N Kidney Problems |
| Y N Asthma | Y N Liver Disease |
| Y N Blood Transfusion | Y N Low Blood Pressure |
| Y N Cancer / Chemotherapy | Y N Lupus |
| Y N Colitis | Y N Mitral Valve Prolapse |
| Y N Congenital Heart Defect | Y N Pacemaker |
| Y N Diabetes | Y N Psychiatric Problems |
| Y N Difficulty Breathing | Y N Radiation Treatment |
| Y N Emphysema | Y N Rheumatic / Scarlet Fever |
| Y N Epilepsy | Y N Seizures |
| Y N Fainting Spells | Y N Shingles |
| Y N Frequent Headaches | Y N Sickle Cell Disease |
| Y N Glaucoma | Y N Sinus Problems |
| Y N Hay Fever | Y N Stroke |
| Y N Heart Attack | Y N Thyroid Problems |
| Y N Heart Murmur | Y N Tuberculosis (TB) |
| Y N Heart Surgery | Y N Ulcers |
| Y N Hemophilia | Y N Venereal Disease |
| Y N Hepatitis | |

Please list any medical condition(s) that you have ever had: _____

Are you allergic to any of the following?

- | | | |
|------------------------|----------------------|------------------|
| Y N Aspirin | Y N Erythromycin | Y N Penicillin |
| Y N Codeine | Y N Jewelry / Metals | Y N Tetracycline |
| Y N Dental Anesthetics | Y N Latex | Y N Other |


Please list any other drugs/materials that you are allergic to: _____

1. What is the reason for today's visit
2. Do you have any questions or concerns we can help you with today?
3. Do you love your smile?
4. Is there anything you would like to change about your teeth or smile?
5. Why did you leave your last dentist?
6. What did you like most about your last dentist?
7. What did you like least about your last dentist?
8. Are you allergic to any metals?.....
If yes, which?.....
9. Have you ever had a skin rash or other reaction to metal jewelry?.....If yes, what kind?
10. Are you allergic to latex?.....
11. Are you concerned about bad breath?.....

Thank You for your time, - Dr. Richard Stauber and Staff

Please Sign

Payment is due in full at time of treatment unless prior arrangements have been approved.

 Thank you for filling out this form completely. It will enable us to help you more effectively. If you have a question at any time, please ask us. We are happy to help.

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

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I verbally reviewed the medical / dental information above with the patient named herein. Initials: _____ Date: _____

Doctor's comments: _____

MEDICAL HISTORY UPDATE

- | | | |
|----------------|-----------------|------------------|
| 1. Date: _____ | Comments: _____ | Signature: _____ |
| 2. Date: _____ | Comments: _____ | Signature: _____ |
| 3. Date: _____ | Comments: _____ | Signature: _____ |