PATIENT MEDICAL INFORMATION

Primary Care Physician Name ______________________________________ Date of last visit ___________________________

Are you currently taking or have ever taken a Bone Health Medication? ○ Fosmax ○ Boniva ○ Actonal ○ Other

Place a mark in the "yes" or "no" to indicate if you have had any of the following:

Condition	Yes / No	Condition	Yes / No	Condition	Yes / No
AIDS/HIV	○ Yes ○ No	Excessive thirst	○ Yes ○ No	Lung disease	○ Yes ○ No
Alzheimer's disease	○ Yes ○ No	Fainting/dizzy spells	○ Yes ○ No	Mitral valve prolapse	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Frequent cough	○ Yes ○ No	Osteoporosis	○ Yes ○ No
Anemia	○ Yes ○ No	Frequent diarrhea	○ Yes ○ No	Parathyroid disease	○ Yes ○ No
Angina	○ Yes ○ No	Frequent headaches	○ Yes ○ No	Psychiatric care	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Genital herpes	○ Yes ○ No	Radiation treatment	○ Yes ○ No
Artificial heart valve	○ Yes ○ No	Glaucoma	○ Yes ○ No	Recent weight loss	○ Yes ○ No
Artificial joints	○ Yes ○ No	Heart attack/failure	○ Yes ○ No	Renal dialysis	○ Yes ○ No
Asthma	○ Yes ○ No	Heart murmur	○ Yes ○ No	Rheumatic fever	○ Yes ○ No
Blood disease	○ Yes ○ No	Heart pacemaker	○ Yes ○ No	Scarlet fever	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Heart problems/disease	○ Yes ○ No	Shingles	○ Yes ○ No
Breathing problem	○ Yes ○ No	Hemophilia	○ Yes ○ No	Sickle cell disease	○ Yes ○ No
Bruise easily	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Sinus trouble	○ Yes ○ No
Cancer	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Spina bifida	○ Yes ○ No
Chemical dependency	○ Yes ○ No	Herpes	○ Yes ○ No	Stomach/intestinal disease	○ Yes ○ No
Chemotherapy	○ Yes ○ No	High blood pressure	○ Yes ○ No	Stroke	○ Yes ○ No
Cold sore / Fever blisters	○ Yes ○ No	High cholesterol	○ Yes ○ No	Swelling of limbs	○ Yes ○ No
Congenital heart disorder	○ Yes ○ No	Hives or rash	○ Yes ○ No	Thyroid disease	○ Yes ○ No
Convulsions	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Tonsillitis	○ Yes ○ No
Cortisone medication	○ Yes ○ No	Irregular heartbeat	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Diabetes	○ Yes ○ No	Kidney problems	○ Yes ○ No	Tumors or growths	○ Yes ○ No
Emphysema	○ Yes ○ No	Leukemia	○ Yes ○ No	Ulcers	○ Yes ○ No
Epilepsy/seizures	○ Yes ○ No	Liver disease	○ Yes ○ No	Venereal disease	○ Yes ○ No
Excessive bleeding	○ Yes ○ No	Low blood pressure	○ Yes ○ no	Yellow Jaundice	○ Yes ○ No

Are you Pregnant/Trying to get pregnant ○ Yes ○ No Nursing ○ Yes ○ No

Pharmacy Name ____

List any medications you are currently taking

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ALLERGIES

Check all that apply

- ○ Aspirin
- ○ Acrylic
- ○ Codeine
- ○ Latex
- ○ Local anesthetic
- ○ Metal
- ○ Penicillin
- ○ Sulfa

PATIENT AUTHORIZATION

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform Mansfield Family Dentistry of any changes in my medical status. I authorize the dental staff to perform necessary dental services that I may need during diagnosis and treatment.

Sign ____ Date _________________________________