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LASER AESTHETIC SURGERY • PORCELAIN VENEERS • INVISALIGN • IMPLANT DENTISTRY

MEDICAL HEALTH HISTORY

Last Name _____ First Name _____ Date of Birth _____Today's Date _____

General Health [*Please Specify*]: Excellent _____ Good _____ Fair _____ Poor _____

Pulse / min: _____ Blood pressure reading: _____

If female: Are you pregnant? _____ How Far in your pregnancy?_____ Due Date? _____

Are you taking Birth Control Pills? [*Please Specify*]_____ When was the last complete physical examination? _____

Who is your / your child's physician: Name _____

Address_____ Phone (_____)_____

Who is your pharmacist? Name & Address _____ Phone (_____)_____

Are you / your child being treated for anything now? _____ Recent Surgery? _____

_____

Did you / your child ever have or had any of the following conditions, disease, or habits [*Please Specify*]:

Kidney Disease / Dialysis _____ Liver Disease_____ AIDS / HIV_____

Tuberculosis_____ Diabetes / Glaucoma _____ Rheumatic Fever_____

Cancer _____ Asthma_____ Anemia _____

Heart Trouble _____ Thyroid Disease _____ Hepatitis _____

Heart Attack [MI] _____ Heart Murmur [MVP] _____ Stroke [CVA] _____

Neurological Conditions _____ Alzheimer _____ Venereal Disease / STD _____

Epilepsy / Seizures _____ Transplants _____ Prosthetics _____

Pacemakers _____ Osteoporosis _____ Osteonecrosis _____

Mental / Physical Disabilities _____ High / Low Blood Pressures _____ Menopause _____

Prolong /Abnormal Bleeding _____ Chemotherapy _____ Radiation Therapy _____

Sinus Conditions _____ TMJ Syndromes / Jaw Pain _____ Headaches _____

Sleeping Disorders_____ Snoring / Sleep Apnea _____ History of Drug / Alcohol Abuse _____

Smoking [Please Specify per Day] _____ Alcohol Consumption _____ Digestive Disorders _____

GERG / Acid Reflux _____ Bulimia / Anorexia _____ Special Diet _____

Immune Disorders _____ Swollen Glands _____ High Gag Reflexes [Gagger] _____

High / Low Cholesterol _____ Speech Impediment _____ Hearing Conditions _____

Latex Sensitivity _____ Epinephrine Sensitivity _____ Neck / Back Pains _____

Attention Deficit Disorder _____ Depression _____ Anxiety _____

Contact Lens / Prescription Glasses _____ Mercury [or Any other Type of Metal] Sensitivity _____

Grinding / Clenching / Para functional Habits [Nail Biting, Cheek Biting, Thumb Sucking, Foreign Objects, etc] _____

Others: _____ Please Explain _____

Are you / your child allergic to: [*Please Specify*] _____

Penicillin _____ Sulfa _____ Iodine _____ Codeine _____ Novocaine / Lidocaine _____ Latex _____ Aspirin _____

Are you / your child allergic to any other drugs? [*Please Specify*] _____

Are you / your child taking any medications now? [*Please Specify*] _____

Are you / your child taking any Bisphosphonates [Fosamax, Boniva, Zometa,……] or any other medications for Osteoporosis ?[*Please Specify*] _____-

_____

Are you / your child taking Aspirin, Plavix, Coumadin, or any other Blood Thinner Medications? [*Please Specify*]_____

_____

Are you / your child "high strung"? _____ Has your / your child's diet ever been evaluated? _____

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian, or Personal Representative Relationship to Patient