PATIENT NAME: ____ **DATE:** ________________

Personal Physician: _____________________________________ (NAME) ______________________ (PHONE NUMBER)

YES	NO	
☐	☐	1. Have you been hospitalized within the past 2 years? For: ____________________
☐	☐	2. Are you currently being treated by a physician? For: ________________________
☐	☐	3. Are you currently taking any medications, drugs, vitamins or supplements? List:____ ____
☐	☐	4. Allergies to foods, drugs, metals, etc...? _________________________________
☐	☐	5. Do you get cold sores, fever blisters or mouth ulcers? How often?______________
☐	☐	6. Women: Are you pregnant or trying to get pregnant? How many weeks? ________
☐	☐	7. Do you smoke? ____ Use smokeless tobacco?____ Vape?____
☐	☐	8. Have you ever had oral or IV bisphosphonates such as Fosamax, Actonel, Boniva, Aredia, Zometa, Skelid or Didronel?

CIRCLE ANY OF THE FOLLOWING CONDITIONS WHICH YOU HAVE HAD?

AIDS/HIV/ARC	Heart Attack	Pacemaker
Alcohol/Drug Addiction	Headaches	Psychiatric Therapy
Arthritis	Hepatitis	Rheumatic Fever
Asthma	High Blood Pressure	Sinus Problems
Cancer	Hip or Knee Replacement	Snoring
Diabetes	Jaw Joint Pain (TMJ)	Stroke
Daily Aspirin Therapy	Kidney Problems	Tuberculosis
Epilepsy	Low Blood Pressure	Other Conditions:
Glaucoma	Mitral Valve Prolapse	____________________
Heart Murmur	Migraine Headaches	____________________

Signature: X_____________________________________ Date: ____________________

Reviewed by Clinician: ______________________________ Date: ____________________

MEDICAL UPDATES

DATE	CHANGES	INTIAL
__________	____	__________
__________	____	__________
________	____	________

MEDICAL ALERTS: ______________________________ **MEDICAL HISTORY AND UPDATE**