HARVARD DENTAL GROUP
MEDICAL HISTORY FORM

Patient Name _____ **Date** _____

Please circle appropriate answer (leave blank if you don't understand the question)

Yes No Is your general health good?
Yes No Has there been a change in your health in the last year? _____
Yes No Are you under the care of a physician? What condition is being treated? _____
Yes No Have you been hospitalized or had a serious illness in the last five (5) years?
If Yes, please explain _____
Yes No Can you climb two flights of stairs?
Yes No Are you in pain now? Describe _____

Are you taking, or have you ever taken, an Antiresorptive bone medication for Osteoporosis, Osteopenia or Cancer related conditions?

Yes / No For how long? _____ If yes, which apply?

_____ Alendronate (Fosamax®) oral _____ Pamidronate (Aredia®) IV
_____ Risedronate (Actonel®) oral _____ Zolendrate (Zometa®) or (Reclast®) IV
_____ Ibandronate (Boniva®) oral/IV _____ Denosumab (Xgeva®) or (Prolia®) injection

Are you taking, or have you ever taken Corticosteroids? Yes/No For how long? _____

Have you ever had, or currently have, the following: (circle Yes/No)
***Check here if none apply** _____

Y N	Radiation Therapy	**Y N**	Bleeding/Bruising Problems	**Y N**	Psychiatric Therapy
Y N	Heart Attack When? _____	**Y N**	Diabetes (Type ____)	**Y N**	Seizures/Epilepsy
Y N	Heart Trouble When? _____		Well Controlled? **Y N**	**Y N**	STD (Syphilis, Herpes or Gonorrhea)
Y N	Artificial Joint	**Y N**	Adrenal Disease	**Y N**	HIV/AIDS
Y N	Pacemaker	**Y N**	Thyroid Disease	**Y N**	Liver Disease/Hepatitis (Type ____)
Y N	Prosthetic Heart Valve	**Y N**	Stroke When? _____	**Y N**	Auto Immune Disorders
Y N	Infective Endocarditis	**Y N**	Fainting/Dizziness	**Y N**	Asthma
Y N	Low Blood Pressure	**Y N**	Kidney Disease	**Y N**	Tuberculosis, Emphysema or
Y N	High Blood Pressure	**Y N**	Allergies/Sinus		Other Lung Disease
Y N	Frequent Headaches	**Y N**	Stomach Ulcer		

Yes No Have you ever had or currently have Cancer or Tumors?

Yes No Allergies to drugs or latex? Please list _____
Yes No Are you taking any prescribed medications or over-the-counter medications? (incl. aspirin & natural remedies)
Please list _____
_____

Have you ever used:
Yes No Tobacco? (cigarettes, cigars, pipes, chewing tobacco)
How much per day? _____ For how long? _____ Quit date _____
Yes No Alcohol?
Yes No Recreational drugs?

Any disease, problem, or prolonged illness not listed on this form? Yes No
If Yes, please explain _____

<u>Women Only</u>

Yes No Birth control? Please list _____
Yes No Are you, or could you be pregnant? If Yes, how far along are you? _____
Yes No Are you nursing?

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medications.

Signature _____ ***Date*** _____
Dentist Signature _____ Date _____ Hygienist Initials _____

Reviewed/Updated: _____ Date: _____ | Reviewed/Updated: _____ Date: _____
Signature *Signature*