FLACK AND STONE

MEDICAL AND DENTAL HISTORY

What is your dental problem?_____

How long has it bothered you?_____

Medical doctor's name:_____Phone #:_____

Previous operations:_____

Current medical problems:_____

List all medications you take: 1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Height:_____ Weight:_____

	YES	NO
Are you wearing contact lenses now?	_____	_____
Do you take more than 4 aspirin a day?	_____	_____
ARE YOU PREGNANT?	_____	_____
Do you take birth control pills?	_____	_____
Do you smoke or chew tobacco? How much?	_____	_____
Do you take any blood thinners? Ie; Plavix, Coumadin	_____	_____
Do you use a C-Pap machine or have sleep apnea?	_____	_____
Do you have tattoos or piercings?	_____	_____
Do you take Aredia, Zometa, Fosamax, or Actonel?(Please Circle)	_____	_____

Please circle any of the following you have had or now have:

Chest Pain or Angina	Angioplasty	Anemia	Bronchitis	Epilepsy
Heart Attack	Stents	Bleeding Problems	Emphysema	Jaw Joint Problems
Heart Disease	Pacemaker	Blood Disease	COPD	Venereal Disease
Arrythmia	Stroke	Diabetes	Tuberculosis	Herpes
Rheumatic Fever	High Blood Pressure	Kidney Problems	Liver Problems	HIV / AIDS
Mitral Valve Prolapse	Low Blood Pressure	Lung Disease	Hepatitis Type ___	
Bypass Surgery	Fainting	Asthma	Cancer	

Allergies to medications:_____

Do you have a heart murmur? Yes_____ No_____ **Joint Replacement Surgery? Yes_____ No_____**

Are there any other medical or dental problems we need to be aware of? If so, please explain:_____

_____

Date:_____**Signature:**_____