NORTHSIDE DENTAL CENTER, PA

MEDICAL HISTORY

Patient Name: _____ DOB: _____

Name of Physician: _____

Are you Allergic to any medications, metals or Latex: Yes: _____ No: _____

If yes, PLEASE list your allergies:

_____

Do you take Blood Thinner or Aspirin: YES NO **How often?** _____

Please list any medications you are currently taking: _____

_____

Have you ever taken any of the following Medications? ***Please circle:*** Acetonel, Aredia, Boniva, Fosomax, Zometa, Ostac, Skelid, or Didronel?

Are there any other medical problems in the past or present, including drugs, surgery, injuries, etc. which we should be aware of? _____

FOR WOMEN ONLY: ***(please circle answer)***

Are you taking birth control: Yes No Are you Pregnant: Yes No

If pregnant, Expected Delivery Date: _____ Are you nursing/breastfeeding? Yes No

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?
(please circle answer)

Heart Trouble:	YES	NO	Epilepsy	YES	NO
Artificial Heart Valves	YES	NO	Hepatitis	YES	NO
Cancer	YES	NO	Asthma	YES	NO
Pacemaker	YES	NO	Bleeding Problems	YES	NO
Joint Replacement	YES	NO	AIDS/HIV	YES	NO
High Blood Pressure	YES	NO	Venereal Disease	YES	NO
Diabetes	YES	NO	Liver Disease	YES	NO
Congenital Heart Lesions	YES	NO	Hearing Impaired	YES	NO

I certify that I have read and understand the questions above. I acknowledge that these questions have been answered to my satisfaction. I will not hold my dentist or any other members of his staff responsible for any errors that I have made in the completion of this form.

Patient Signature: _____ Date: _____

Parent/Guardian (if patient is a minor): _____ Date: _____

NORTHSIDE DENTAL CENTER, PA

Have you had any changes in the above since your last oral exam? YES NO

Please list all HEALTH or MEDICATION changes below: (or write "No Changes")

Signature: ____ Date: ________________________

Have you had any changes in the above since your last oral exam? YES NO

Please list all HEALTH or MEDICATION changes below: (or write "No Changes")

Signature: ____ Date: ________________________

Have you had any changes in the above since your last oral exam? YES NO

Please list all HEALTH or MEDICATION changes below: (or write "No Changes")

Signature: ____ Date: ________________________

Have you had any changes in the above since your last oral exam? YES NO

Please list all HEALTH or MEDICATION changes below: (or write "No Changes")

Signature: ____ Date: ________________________

Have you had any changes in the above since your last oral exam? YES NO

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Signature: ____ Date: ________________________