Medical History

Patient Name:_____ **Birth Date:**_____ **Age:**____ **E-mail address:**_____

Name of family Physician:_____ **Physician Phone#**_____

Physicians Address:_____

Are you in good health? Y / N **Do you have ANY health changes?**_____

Do you have, or have you had , any of the following? (please circle)

Heart Disease	Seizures	Thyroid Disease	Lung Disease	Psychiatric Therapy
High Blood Pressure	Fainting	Anemia	Tuberculosis	Kidney Disease
Artificial Heart Valve	Arthritis	Blood Disease	Asthma/Emphysema	Venereal Disease
Rheumatic Fever	Ulcers	Bleeding Disorder	Allergies	Joint Replacement
Heart Murmur	Tumor History	Hepatitis	Sinus Trouble	Cough
Stroke	Radiation Therapy	Liver Disease	HIV / AIDS	Epilepsy
Diabetes	Chemotherapy	Bone Disease	Hysterectomy	Latex Allergy

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

Y / N Do you use Alcohol?
Y / N Do you use Tobacco?
Y / N Have you ever been hospitalized and /or had surgery? (if yes, please list most recent:)
When:_____ **Why:**_____
When:_____ **Why:**_____
Y / N Are you under the care of a physician now? Explain:_____
_____
Y / N Are you taking medication, drugs, pills, vitamins or herbal supplements? If yes, list:_____
_____
Y / N Are you allergic or sensitive to aspirin, penicillin, or any other drugs or medication? Explain:_____
_____
Y / N Have you ever been treated for cancer with an I.V. drug like Zometa or Aredia?
Y / N Have you ever taken Fosomax or a bisphosphnate drug? If so, How long?_____**years**____**months.**
Y / N Do you have any disease, condition or problem not listed above? If yes, list:_____
Y / N Have you ever had any excessive bleeding requiring special treatment?
Y / N Have you ever had a blood test for hepatitis? If so, were you vaccinated? _____**yes** ____**no**
Y / N Have you had canker or cold sores on your lips, tongue, or gums?
Y / N If female, are you pregnant? Due date _____ **Post menopause?**_____
Y / N If female, are you nursing?
Y / N Have you been out of the United States in the past 6 months? Where?_____

I consent to treatment as necessary or desirable to care of the patient first named above, for diagnosis or dental disease, deformity, or treatment of dental emergency. In case of dental emergency, I consent to treatment, as deemed necessary by the doctor, understanding the procedures will be explained in advance. I understand it is soley my responsibility to report any changes in the above information to this office. I consent to my x-rays and dental records being sent to Family & Cosmetic Dentistry of the Rockies for their use.

Signed:_____ **Date**_____ **Dentist** _____
Patient / Parent / Guardian

Travis R. Willey, D.D.S. / Brandon M. Murri, D.M.D.

Printed Name_____