Medical History Update

Patient Name:	Medical Alert:

1. Have you been under the care of a medical doctor during the past two years? Yes No
2. Are you taking any medication, drug or pills now, including regular dosage of aspirin? Yes No
   If yes, please list name and dosage:

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3. Are you aware of having an allergic (or adverse) reaction to any medication or substance? Yes No
4. Are you now or have you in the past taken osteoporosis medicine? Yes No

Indicate which of the following you have had in the past or presently have.
Circle each line "Yes" or "No"

Heart (Surgery, Disease, Attack)	Yes	No
Heart Murmur	Yes	No
High Blood Pressure	Yes	No
Mitral Valve Prolapse	Yes	No
Artificial Heart Valve	Yes	No
Heart Pacemaker	Yes	No
Rheumatic Fever	Yes	No
Stroke	Yes	No
Artificial Joint(hip, knee, etc.)	Yes	No
Kidney Trouble	Yes	No
Diabetes	Yes	No
Tuberculosis	Yes	No
Asthma	Yes	No
Latex Sensitivity	Yes	No
Radiation Therapy	Yes	No
Chemotherapy	Yes	No
Hepatitis A (infectious) B (serum) C	Yes	No
Venereal Disease	Yes	No
A.I.D.S.	Yes	No
HIV Positive	Yes	No
Epilepsy or Seizures	Yes	No

Do you have or have had any condition, disease, or problem not listed? Yes No
If yes, please list: _____

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Patient/Guardian Signature _____ Date _____

History Review & Dentist Signature