ARISE DENTAL Medical History

Patient Name: _____ DOB: ____/____/____

Are you currently under the care of a physician? If YES, Name: _____

Physician's Name: _____ Physician's Phone #: _____

Describe your current physical health: ❑ Excellent ❑ Fair ❑ Poor

Do you Smoke or use Smokeless Tobacco? ❑ Yes ❑ No Specify: _____

FOR WOMEN: Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No If yes, # of weeks _____ Are you nursing? ❑ Yes ❑ No

❑ Y ❑ N Have you ever taken Boniva or Alendronate (Fosamax)? _____

Are you currently taking any ❑ prescriptions ❑ over the counter drugs ❑ herbal supplements ❑ appetite suppressants?

Do you now or have you ever had any of the following medical conditions?

❑ Y ❑ N Heart Disease / Defect
❑ Y ❑ N Heart Murmur
❑ Y ❑ N Irregular Heart Beat
❑ Y ❑ N Angina / Chest Pain
❑ Y ❑ N Heart Attack
❑ Y ❑ N Heart Failure
❑ Y ❑ N Rheumatic Fever
❑ Y ❑ N Mitral Valve Prolapse
❑ Y ❑ N Artificial Heart Valve
❑ Y ❑ N Heart Pacemaker
❑ Y ❑ N Heart Surgery
❑ Y ❑ N High Blood Pressure
❑ Y ❑ N Low Blood Pressure
❑ Y ❑ N Blood Disease
❑ Y ❑ N Stroke
❑ Y ❑ N Bruise Easily
❑ Y ❑ N Anemia
❑ Y ❑ N Excessive Bleeding

❑ Y ❑ N Hemophilia
❑ Y ❑ N Leukemia
❑ Y ❑ N Allergies (Seasonal)
❑ Y ❑ N Pain in the Jaw
❑ Y ❑ N Lung Disease
❑ Y ❑ N Breathing Problems
❑ Y ❑ N Tuberculosis (TB)
❑ Y ❑ N Sinus Problems
❑ Y ❑ N Asthma - type: _____
❑ Y ❑ N Emphysema
❑ Y ❑ N Thyroid Disease
❑ Y ❑ N Fainting / Dizziness
❑ Y ❑ N Cancer
❑ Y ❑ N Radiation Treatment
❑ Y ❑ N Chemotherapy
❑ Y ❑ N Artificial Joint: _____
❑ Y ❑ N AIDS / HIV Positive
❑ Y ❑ N Autoimmune Disease: _____

❑ Y ❑ N Osteoporosis / Osteopenia
❑ Y ❑ N Stomach / Intestinal Disease
❑ Y ❑ N Ulcers
❑ Y ❑ N Convulsions / Seizures
❑ Y ❑ N Epilepsy
❑ Y ❑ N Diabetes - type: _____
❑ Y ❑ N Hypoglycemia
❑ Y ❑ N Liver Disease
❑ Y ❑ N Hepatitis - type: _____
❑ Y ❑ N Jaundice
❑ Y ❑ N Kidney Problems
❑ Y ❑ N Arthritis - type: _____
❑ Y ❑ N Drug Use / Addiction
❑ Y ❑ N Alcohol Addiction
❑ Y ❑ N Cold Sores / Fever Blisters
❑ Y ❑ N Nervousness
❑ Y ❑ N Depression
❑ Y ❑ N Other: _____

Are you allergic to any of the following?

❑ Y ❑ N Aspirin
❑ Y ❑ N Codeine
❑ Y ❑ N Dental Anesthetics

❑ Y ❑ N Erythromycin
❑ Y ❑ N Jewelry / Metals
❑ Y ❑ N Latex

❑ Y ❑ N Penicillin
❑ Y ❑ N Tetracycline
❑ Y ❑ N Other: _____

❑ Y ❑ N Have you ever been hospitalized or had any major operations? _____

Please list any over-the-counter or prescription drugs that you are currently taking.

Medication	Dosage	Reason for Taking Medication

Patient Signature: _____ Date: _____