El Paso Quality Dentistry, P.A.

Medical History

Medical Doctor's Name_____
Date of Most Recent Visit _____
Have you had any serious illness or operation in the past two years? ☐ yes ☐no
Describe_____

Have you been treated or diagnosed for any of the following? (Please Check)

☐ AIDS
☐Anemia
☐Arthritis/Rheumatism
☐Artificial Heart Valves
☐Artificial Joints
☐Asthma
☐Back Problems
☐Blood Disease
☐Cancer
☐Chemical Dependency
☐Chemotherapy
☐Circulatory Problems
☐Cortisone Treatment
☐Cough, Persistent
☐Cough up Blood
☐Diabetes
☐Blood Transfusion
☐Drugs/Alcohol Addiction
☐Epilepsy
☐Fainting
☐Glaucoma
☐Headaches
☐Heart Murmur
☐Heart Problem
☐Hemophilia
☐Hepatitis
☐High Blood Pressure
☐HIV Positive
☐Jaw Pain
☐Kidney Disease
☐Liver Disease
☐Mitral Valve Prolapse
☐Depression
☐Pacemaker
☐Psychiatric Care
☐Radiation Treatment
☐Respiratory Disease
☐Rheumatic Fever
☐Scarlet Fever
☐Shortness of Breath
☐Skin Rash
☐Stroke
☐Swelling Feet/Ankles
☐Thyroid Problems
☐Tobacco Habit
☐Tonsillitis
☐Tuberculosis
☐Ulcer
☐Venereal Disease

List any medications you are taking including over the counter drugs and prescription drugs.

_____ _____ _____ _____
_____ _____ _____ _____

Are you / have you taken any bisphosphonates in the past 5 years: ☐NO
☐ YES:_____

Are you allergic to any medication? ☐Antibiotics ☐pain medication
☐Other? _____

(Women) Are you pregnant? ☐Yes ☐no Nursing ☐yes ☐no
Taking hormones? ☐yes ☐no Birth Control Pills ☐yes ☐no

Pharmacy of Choice_____

Patient's Signature _____Date_____

Print Name _____