jlh JEFFREY L. HARDENBURG D.D.S.

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Medical History

Patient Name _____ **Gender** male ◯ female ◯

1. Have you been under the care of a medical doctor during the last two years? **yes** ◯ **no** ◯ If yes, for what?

Physician Name _____ Phone No. _____

2. List any medications you are currently taking:

3. Are you aware of having an allergic (or adverse reaction) to any medication or substance? (Such as Penicillin, Aspirin, Tetracycline, Dental Anesthesia, Codeine, Latex or other) **yes** ◯ **no** ◯ If yes, please list the names?

4. Have you been a patient in a hospital during the last five years? **yes** ◯ **no** ◯ If yes, for what?

5. Have you taken or are you taking any bisphosphonates within the last ten years (Fosamax, Actonel, Aredia or Zometa)? **yes** ◯ **no** ◯

6. Indicate which of the following you have had or have at present. Check yes or no for each item.

yes	no		yes	no		yes	no	
◯	◯	Heart (Surgery, Disease, Attack)	◯	◯	Diabetes	◯	◯	Venereal Disease
◯	◯	Heart Murmur	◯	◯	Thyroid Problems	◯	◯	AIDS
◯	◯	High/Low Blood Pressure	◯	◯	Glaucoma	◯	◯	HIV Positive
◯	◯	Mitral Valve Prolapse	◯	◯	Lupus	◯	◯	Cold Sores/Fever Blisters Blood
◯	◯	Artificial Heart Valve	◯	◯	Emphysema	◯	◯	Transfusion
◯	◯	Heart Pacemaker	◯	◯	Tuberculosis	◯	◯	Hemophilia
◯	◯	Osteoarthritis	◯	◯	Asthma	◯	◯	Liver Disease
◯	◯	Rheumatoid/Arthritis	◯	◯	Sinus Trouble	◯	◯	Neurological Disorders
◯	◯	Steroids/Cortisone Medicine	◯	◯	Radiation Therapy	◯	◯	Epilepsy or Seizures
◯	◯	Stroke	◯	◯	Chemotherapy	◯	◯	Fainting or Dizzy Spells
◯	◯	Artificial Joints (Hip, Knee, etc.)	◯	◯	Cancer	◯	◯	Nervous/Anxious
◯	◯	Kidney Trouble (Transplant)	◯	◯	Anemia	◯	◯	Psychiatric/Psychological Care
◯	◯	Eating Disorders	◯	◯	Hepatitis			

7. Do you use controlled substances (drugs)? **yes** ◯ **no** ◯ Do you or have you suffered from drug addiction? **yes** ◯ **no** ◯
8. Have you lost or gained more than twenty pounds in the past year? **yes** ◯ **no** ◯
9. Do you have or have you had any disease, condition or problem not listed? **yes** ◯ **no** ◯ If yes, please describe:
10. Women. Are you pregnant? **yes** ◯ **no** ◯
11. Have you ever had any excessive bleeding requiring special treatment? **yes** ◯ **no** ◯
12. When you walk up stairs or take a walk, do you ever stop because of pain in your chest, shortness of breath or because you feel tired? **yes** ◯ **no** ◯

Do you have any further questions, concerns or additional information or is there anything else about having dental treatment that you would like to know? yes ◯ no ◯ If yes, please describe:

I understand the above information is necessary to provide appropriate treatment and I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release information to you. I will notify Dr. Hardenburg of any change in my health or medication.

Patient Signature:_____ **Date:** _____

Please bring a completed copy of this form with you on your scheduled office appointment.

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