



Medical History

Luke A. Foster, DDS
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Patient Name _____ Date of Birth _____ Sex: M F

Medical doctor/clinic _____ Pharmacy _____

- Y N Are you taking any prescription or non-prescription medications, vitamins, herbals, or supplements? (if yes, please list on back of this form or attach separate sheets)
- Y N Are you allergic to any medication, local anesthetic, or materials?
- Y N Have you ever had heart trouble?
- Y N Do you have high/low blood pressure?
- Y N Have you ever had a joint replacement? Which joint(s) _____ When _____
- Y N Have you ever been advised to take antibiotics before dental treatment?
- Y N Do you have a pacemaker?
- Y N Do you have diabetes? Type 1 Type 2
Last HbA1c level _____ Date _____
- Y N Have you had any major surgery?
- Y N Have you ever had a serious accident involving head injuries?
- Y N Do you have a history of fainting?
- Y N Have you been hospitalized within the past year?
- Y N Do you use tobacco products? Which _____
- Y N Have you ever bled excessively after being cut or injured?
- Y N Have you had radiation, chemotherapy, or other cancer treatment?
- Y N Have you tested HIV positive? Do you have AIDS?
- Y N Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?

Do you have or have you ever had:

- Y N Any heart condition
- Y N Stroke
- Y N Heart attack
- Y N Artificial/prosthetic heart valve
- Y N Congenital heart disease (heart defects at birth)
- Y N Organ transplant
- Y N Bacterial endocarditis
- Y N High cholesterol
- Y N Thyroid condition
- Y N Hepatitis or liver disease
- Y N Epilepsy or seizure
- Y N Ulcer or GERD
- Y N Breathing problems
- Y N Asthma
- Y N Sinus problems
- Y N Tuberculosis
- Y N Kidney problems
- Y N Cancer or malignancy
- Y N Sexually transmitted disease
- Y N Osteoporosis
- Y N Drug addiction

Women:

- Y N Are you pregnant or trying to get pregnant?
- Y N Are you taking oral contraceptives?
- Y N Are you nursing?

Please explain "yes" answers (use the back of this form if more space is needed):

Patient (or guardian) signature _____ Date _____

Reviewed with patient by _____ Date _____ BP _____

