JOSEPH C. STYGER, D.D.S., INC. **MEDICAL HISTORY**

Patient Name

1. Physician's Name ______________________________________Phone (   )_____________________
   Have you had any medical care within the past two years?.. Yes No
   Describe____
2. Have you taken any medication or drugs during the past two years?... Yes No
   If yes, please list name and dosage____
3. Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin?. Yes No
   If yes, please list name and dosage____
4. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Bonivia or other bisphosphonates? Yes No
   If yes, please list name and dosage____
5. Are you aware of having **allergic (or adverse)** reaction to any substance or medication?.................................. Yes No
   If yes, please specify____
6. Have you been a patient in the hospital during the past five years?... Yes No
7. Indicate which of the following you have had, or have at present. Circle "Y" for yes or "N" for no to each item.

Heart (Surgery, Disease, Attack)	Y	N	Ulcers	Y	N	Hepatitis A B C (Circle)	Y	N
Chest Pain	Y	N	Diabetes	Y	N	Venereal Disease	Y	N
Congenital Heart Disease	Y	N	Thyroid Problems	Y	N	A.I.D.S/H.IV. Positive	Y	N
Heart Murmur	Y	N	Glaucoma	Y	N	Cold Sores/Fever Blister	Y	N
High/Low Blood Pressure	Y	N	Contact Lenses	Y	N	Blood Transfusion	Y	N
Mitral Valve Prolapse	Y	N	Emphysema	Y	N	Hemophilia	Y	N
Artificial Heart Valve/Pacemaker	Y	N	Chronic Cough	Y	N	Sickle Cell Disease	Y	N
Rheumatic Fever	Y	N	Tuberculosis	Y	N	Bruise Easily	Y	N
Arthritis/Rheumatism	Y	N	Asthma	Y	N	Liver Disease/Yellow/Jaundice	Y	N
Cortisone Medicine	Y	N	Hay Fever/Allergy/Hives	Y	N	Neurological Disorders	Y	N
Swollen Ankles	Y	N	Latex Sensitivity	Y	N	Epilepsy or Seizures	Y	N
Stroke	Y	N	Sinus Trouble	Y	N	Fainting or Dizzy Spells	Y	N
Diet (Special/Restricted)	Y	N	Radiation Therapy	Y	N	Nervous/Anxious	Y	N
Artificial Joints (hip, knee, etc)	Y	N	Chemotherapy	Y	N	Psychiatric/Psychological Care	Y	N
Kidney Trouble	Y	N	Tumors	Y	N	Others please list below	Y	N
Disease, condition or problem not listed:								

8. Have you lost or gained more than 10 pounds in the past year?.. Yes No
9. Women: Are you pregnant or think you could be pregnant? Yes _________Months No Nursing Yes No
10. Do you use birth control prescriptions?.. Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. 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 such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature____ Date_______________________________

Dentist Signature____ Date_______________________________