Gentle Dentistry of Columbus, P.C.
Darcy R. Leerssen, D.D.S. Jeffery A. King, D.M.D.

MEDICAL HISTORY

Name _____Date: _____

Primary Care Physician: _____ Phone _____

Have you ever had any of the following: Please check any that apply.

__Chest Pain	__AIDS/HIV	__Epilepsy	__ Rheumatic Fever
__Congenital Heart Defect	__Allergies	__Excessive Bleeding	__Seizures
__Heart Attack	__Arthritis	__Hepatitis Type A B C	__Stroke
__Heart Disease	__Asthma	__High Blood Pressure	__Tuberculosis
__Heart Valve Replacement	__Cancer	__Kidney Disease	
__Mitral Valve Proplapse	__Diabetes	__Liver Disease	

Are you Allergic to any Medicines or Drugs? **YES NO**
Please List

Are you under the care of a physician now? **YES NO**
Please List Condition

Are you taking any medicine now or in the past year **YES NO**
Please List

Have you ever had any complication from taking local anesthesia? **YES NO**
Have you ever had any operations? **YES NO**
Please list

Have had any serious Illness? **YES NO**
Have you had any joint replacements? **YES NO**
Have you ever been treated for Osteoporosis, Low Bone Density, Bone Loss or Paget's Disease? **YES NO**
Have you been treated intravenously or by mouth with Bisphosphonates (Zometa, Reclast, Aredia, Alendro, Actonel, Boniva, Fosomax) for bone problems? **YES NO**
Do you smoke? **YES NO**
(Female) are you pregnant? **YES NO**

COMMENTS:

To the best of my knowledge the above confidential information is true. If the above named patient is a minor, I also give my permission for treatment.
Signed_____ **Date** _____