Gentle Dentistry of Columbus

Darcy R. Leerssen, D.D.S. Devon A. Paris, 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
__Congenital Heart Defect
__Heart Attack
__Heart Disease
__Heart Valve Replacement
__Mitral Valve Proplapse
__AIDS/HIV
__Allergies
__Arthritis
__Asthma
__Cancer
__Diabetes
__Epilepsy
__Excessive Bleeding
__Hepatitis Type A B C
__High Blood Pressure
__Kidney Disease
__Liver Disease
__ Rheumatic Fever
__Seizures
__Stroke
__Tuberculosis

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. I give permission for my clinical treatment. If the above named patient is a minor, I give my permission for their treatment.
Signed____ **Date** ___________________