AGAVE DENTAL

Medical History

Patient Name: _____ DOB: ____/____/____

Are you currently under the care of a physician ❑ Yes ❑ No? If YES, please provide the following: _____

Physician's Name: _____ Physician's Phone #: _____

Describe your current physical health: ❑ Excellent ❑ Fair ❑ Poor

Do you Smoke or use Smokeless Tobacco? ❑ Yes ❑ No Please circle any that apply: Cigarettes Cigars Vape Marijuana Chew Other_____

FOR WOMEN: Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No If yes, # of weeks _____ Are you nursing? ❑ Yes ❑ No

❑ Y ❑ N Have you ever taken Boniva or Alendronate (Fosamax)? _____

Do you now or have you ever had any of the following medical conditions?

❑ Y ❑ N Blood Conditions (Check all that apply)
- ❑ Anemia
- ❑ Bruise Easily
- ❑ Hemophilia

❑ Y ❑ N Bone / Joint (Check all that apply)
- ❑ Artificial Joint: _____
- ❑ Arthritis - type: _____
- ❑ Pain in the Jaw
- ❑ Osteoporosis / Osteopenia

❑ Y ❑ N Cancer (Check all that apply)
- ❑ Leukemia
- ❑ Radiation Treatment
- ❑ Chemotherapy

❑ Y ❑ N Heart Conditions (Check all that apply)
- ❑ Angina / Chest Pain
- ❑ Artificial Heart Valve
- ❑ Heart Attack
- ❑ Heart Disease / Defect
- ❑ Heart Failure

Heart Conditions Continued
- ❑ Heart Pacemaker
- ❑ Heart Surgery
- ❑ High Blood Pressure
- ❑ Irregular Heart Beat
- ❑ Low Blood Pressure
- ❑ Mitral Valve Prolapse
- ❑ Stroke

❑ Y ❑ N Lung Conditions (Check all that apply)
- ❑ Breathing Problems
- ❑ Tuberculosis (TB)
- ❑ Asthma - type: _____
- ❑ Emphysema / COPD

❑ Y ❑ N Stomach / Intestinal Condition (Check all that apply)
- ❑ Ulcers
- ❑ Liver Disease
- ❑ Hepatitis - type: _____
- ❑ Kidney Problems

❑ Y ❑ N AIDS / HIV Positive
❑ Y ❑ N Allergies (Seasonal)
❑ Y ❑ N Autoimmune Disease: _____
❑ Y ❑ N Cold Sores / Fever Blisters
❑ Y ❑ N Depression
❑ Y ❑ N Diabetes - type: _____
❑ Y ❑ N Drug Use / Addiction
❑ Y ❑ N Epilepsy / Seizures
❑ Y ❑ N Fainting / Dizziness
❑ Y ❑ N Hypoglycemia
❑ Y ❑ N Nervousness
❑ Y ❑ N Rheumatic Fever
❑ Y ❑ N Sinus Problems
❑ Y ❑ N Thyroid Disease
❑ Y ❑ N Other: _____

Are you allergic to any of the following?

❑ Y ❑ N Aspirin
❑ Y ❑ N Codeine
❑ Y ❑ N Dental Anesthetics
❑ Y ❑ N Erythromycin
❑ Y ❑ N Jewelry / Metals
❑ Y ❑ N Latex
❑ Y ❑ N Penicillin
❑ Y ❑ N Tetracycline
❑ Y ❑ N Other: _____

❑ Y ❑ N Have you ever been hospitalized or had any major surgeries? Please specify:_____

Please list any over-the-counter and prescription medications that you are currently taking, including supplements.

Medication / mg	Dosage	Reason for Taking Medication

Patient Signature: _____ **Date:** _____