PRINCETON PARK DENTAL ASSOCIATES, P.A.
CONFIDENTIAL MEDICAL HISTORY

Patient Name _____ Date of Birth_____

Name, address and phone number of your physician: _____

_____

Approximate date of your last physical exam: _____

PLEASE CIRCLE THE ANSWER THAT BEST APPLIES TO YOU

YES NO Are you under the care of a physician for any recent illness or surgery?
If yes, please describe: _____

YES NO Are you taking or have you taken any of the following medications: Fosamax, Actonel, Bonivia, Aredia, Zometa or any medication containing chemical bisphosphonates?
If yes, please specify:_____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING (including vitamins and herbal supplements)

_____

_____

HAVE YOU HAD ANY OF THE FOLLOWING?

Yes	No	Rheumatic fever	Yes	No	Sleep apnea
Yes	No	Heart murmur	Yes	No	STDs or communicable diseases
Yes	No	Heart / bypass surgery	Yes	No	Psychological or emotional problems
Yes	No	Mitral valve prolapse	Yes	No	HIV positive or AIDS
Yes	No	Prosthetic (artificial) heart valve	Yes	No	Epilepsy, seizures, convulsions
Yes	No	Cardiac stents	Yes	No	Stomach, digestive problems, ulcers
Yes	No	Organ transplants	Yes	No	GERD (reflux)
Yes	No	Stroke/TIA	Yes	No	Thyroid disease
Yes	No	Pacemaker or defibrillator	Yes	No	Autoimmune disorders
Yes	No	Fainting	Yes	No	Fibromyalgia
Yes	No	Bleeding problems; hemophilia			
Yes	No	High blood pressure			
Yes	No	Anemia			
Yes	No	Asthma, breathing problems,emphysema			
Yes	No	Allergies (i.e. Hayfever, etc.)			
Yes	No	Hepatitis A B C ___			
Yes	No	Jaundice, liver problems			
Yes	No	Renal dialysis, shunt			
Yes	No	Sinusitis			
Yes	No	Tuberculosis			
Yes	No	Kidney or urinary problems			
Yes	No	Radiation or X-ray treatment			
Yes	No	Chemotherapy, central venous catheter			
Yes	No	Cancer or tumors			
Yes	No	Arthritis			
Yes	No	Artificial joints			
Yes	No	Diabetes			
Yes	No	Others, please specify_____			

HAVE YOU HAD A BAD REACTION TO:

Yes No Latex
Yes No Local anesthetics (Novocaine etc.)
Yes No Nitrous oxide
Yes No Oral surgery or tooth extraction
Yes No Penicillin or other antibiotics
Yes No Other drugs or medication
Specify: _____

WOMEN

Yes No Are you taking birth control pills?
Yes No Are you pregnant?
Yes No Are you menopausal?
Remarks: _____
_____

Any medical problems not listed above? _____

In the event of a medical emergency, whom should we contact? _____

Relationship_____ Phone # _____

Patient's (Parent or Guardian) Signature_____ Date_____