Thomas J. Gilbert, DDS

MEDICAL HISTORY

Today's Date_____ Patient Name_____ Date of birth:_____

Name of Physician: _____ City, State _____ Phone _____

Y N

1. Are you currently being treated for any medical condition?..... ☐☐
   Please List_____
2. Have you ever been hospitalized or had a major operation?..... ☐☐
   Please List_____
3. Have you ever taken Fosamax, Boniva, Actonel or another bisphosphonate medication?..... ☐☐
4. Have you had a joint (hip, knee, elbow) replacement? ☐☐ Date: _____ any complications? ☐☐
5. Do you smoke or use tobacco (chew), e-cigs or hookah?..... ☐☐
6. Do you drink alcoholic beverages? ☐☐ How much do you typically drink in one week? _____

DO YOU HAVE OR HAVE YOU EVER HAD:

Allergies to any medications? ☐Aspirin ☐Penicillin ☐Codeine ☐Acrylic ☐Latex ☐Metal ☐Sulfa ☐Local anesthetic

☐ Other?_____

Please enter	**Y N**
birth control/pregnant/nursing	☐☐
Cancer/Chemotherapy/Radiation	☐☐
Cardiovascular disease	☐☐
Chronic Pain	☐☐
Cold sores/fever blisters	☐☐
Heart attack/Failure	☐☐
Diabetes: type I II (circle one)	
Herpes	☐☐
Angina	☐☐
Gastrointestinal disease	☐☐
Lingering laryngitis/sore throat	☐☐
Arteriosclerosis	☐☐
GI Reflux/persistent heartburn	☐☐
Difficulty swallowing	☐☐
Heart Disease	☐☐
severe headaches/migraines	☐☐
osteoporosis	☐☐
Autoimmune Disease	☐☐
Arthritis/Rheumatoid/Lupus	☐☐
AIDS/HIV	☐☐
Low Blood Pressure	☐☐
High Blood Pressure	☐☐
Asthma	☐☐
Liver disease or jaundice	☐☐
Pacemaker	☐☐
Ulcers	☐☐
kidney problems	☐☐
Abnormal Bleeding	☐☐
Thyroid/Parathyroid	☐☐
sleep disorder	☐☐
Blood thinners	☐☐
Stroke	☐☐
behavioral /psych disorders	☐☐
Anemia or blood disease	☐☐
hepatitis……Type A B C (circle one)	
Hemophilia	☐☐
Epilepsy or seizures	☐☐

LIST ALL PRESCRIPTION AND OVER-THE-COUNTER VITAMINS, NATURAL, HERBAL OR DIETARY SUPPLEMENTS

Drug Name Amount Frequency Purpose	Drug Name Amount Frequency Purpose

Preferred pharmacy: _____ Phone number:_____ Location_____

Patient signature_____Date: _____

Please advise changes to Medical History at each visit:

Date:_____ MHU_____

Date:_____ MHU_____

Date:_____ MHU_____

Date:_____ MHU_____