Matthew H. Wallengren, D.D.S., P.A.
600 Wyndhurst Avenue, Suite 270
Baltimore, MD 21210

PATIENT MEDICAL HISTORY

Patient's Name _____ DOB _____

Physician's Name _____

Address _____ Phone # _____

NOTES

1. Are you under a physicians care? ..... YES NO
   Since when? _____ Why? _____

2. When was your last physical exam? _____
3. Are you allergic to medications or substances? ..... YES NO
4. Do you have any problems with Penicillin, antibiotics or other medications? ..... YES NO
5. If so, please list drug/food dye allergies _____

6. Are you sensitive to metals? ..... YES NO
7. Are you pregnant or suspect you may be? ..... YES NO
8. Do you use any birth control medications? ..... YES NO

9. Have you ever been treated or told you might have heart disease? ..... YES NO
10. Do you have high or low blood pressure? ..... YES NO
11. Are you aware of any heart murmur? ..... YES NO
12. Have you ever had rheumatic fever? ..... YES NO
13. Do you have a pacemaker or an artificial heart valve? ..... YES NO

14. Have you ever had a serious illness or major surgery? ..... YES NO
15. Have you ever had radiation treatment or chemo treatment for a tumor? ..... YES NO
16. Do you have arthritis or rheumatism? ..... YES NO
17. Do you have bleeding problems? ..... YES NO

18. Do you have any artificial joints or prosthetics? ..... YES NO
19. Are you diabetic? ..... YES NO
20. Do you have asthma? ..... YES NO
21. Do you have epilepsy or seizure disorder? ..... YES NO
22. Do you have thyroid problems? ..... YES NO
23. Do you have stomach problems? ..... YES NO
24. Do you have any kidney problems? ..... YES NO
25. Do you have any liver problems? ..... YES NO
26. Have you tested positive for HIV/AIDS? ..... YES NO
27. Do you have or have you tested positive for hepatitis? ..... YES NO
28. Do you have T.B.? ..... YES NO

29. Do you smoke, chew, use snuff or other forms of tobacco? ..... YES NO
30. Do you habitually use controlled substances? ..... YES NO
31. Do you consume alcoholic beverages? ..... YES NO
32. Do you have any disease, condition or problem not listed? ..... YES NO
    If so, please explain _____

33. Is there anything else we should know about your health that we have not covered in this form?_____

34. Would you like to speak with the doctor privately about any problem?..... YES NO

NOTES

35. ARE YOU USING ANY OF THE FOLLOWING

A. Antibiotics?..... YES NO
B. Anticoagulants (Blood Thinners)?..... YES NO
C. Aspirin, Motrin, Aleve, Ibuprofen?..... YES NO
D. High Blood Pressure Medication?..... YES NO
E. Steroids (Cortisone, Prednidsone, etc)?..... YES NO
F. Tranquilizers?..... YES NO
G. Insulin or Oral Anti-Diabetic drugs?..... YES NO
H. Digitalis, Inderal, Nitroglycerin or other heart drugs?..... YES NO
I. Are you taking or ***have you ever taken*** Bisphosphonates for osteoporosis, multiple myeloma, or other cancers.(Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa)?..... YES NO
J. Have you ever been advised NOT to take a medication?..... YES NO
K. Are you taking any medications?..... YES NO
L. Please list any and all medications taken, including prescription medications, Diet drugs, over-the-counter medications, herbal or holistic remedies, vitamins or minerals.

_____
_____
_____
_____
_____
_____
_____
_____
_____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

Patient's Signature_____ **Date**_____

Doctor's Signature_____ **Date**_____