Patient Medical History
Dr. Robert Metzger, DDS

Patient Name_____ **Date of Birth**_____

Physician Name_____ **Physician Phone**_____

Pharmacy_____ **Pharmacy Phone**_____

Do you have or have you had any of the following:

Yes No	Abnormal Bleeding	Yes No	Diabetes	Yes No	Low Blood Pressure
Yes No	AIDS/HIV	Yes No	Emphysema	Yes No	Mitral Valve Prolapse
Yes No	Anemia	Yes No	Endocarditis	Yes No	Pacemaker
Yes No	Arthritis	Yes No	Fainting or Dizziness	Yes No	Psychiatric Care
Yes No	Artificial Heart Valves	Yes No	Glaucoma	Yes No	Radiation Treatment
Yes No	Artificial Joints	Yes No	Headaches	Yes No	Respiratory Disease
Yes No	Asthma	Yes No	Heart Problems	Yes No	Rheumatic Fever
Yes No	Blood Disease	Yes No	Heart Transplant	Yes No	Shingles
Yes No	Cancer	Yes No	Hepatitis Type_____	Yes No	Stroke
Yes No	Chemical Dependency	Yes No	Herpes	Yes No	Thyroid Problems
Yes No	Chemotherapy	Yes No	High Blood Pressure	Yes No	Tuberculosis
Yes No	Congenital Heart Defect	Yes No	Kidney Disease	Yes No	Tumor/Growth
Yes No	Dementia or Alzheimer's	Yes No	Liver Disease	Yes No	Venereal Disease

Yes No **Do you have any disease, condition or problem not listed above? Please describe**_____

Yes No **Have you ever taken any of the group of drugs referred to as bisphosphonates, for osteoporosis, multiple myeloma, or other cancers? These include Actonel, Boniva, Zometa, Aredia, Fosamax and Reclast.**

Yes No **Do you smoke or use tobacco**

Women: Yes No **Are you pregnant? Due Date**_____ Yes No **Are you nursing?** Yes No **Are you using Birth Control?**

Allergies

Yes No	Aspirin	Yes No	Latex
Yes No	Codeine	Yes No	Metals
Yes No	Dental Anesthetics	Yes No	Penicillin
Yes No	Erythromycin	Yes No	Sulfa
Yes No	Jewelry	Yes No	Tetracycline
Yes No	Other_____		

Medications

List any medications you are taking (include over the counter)

_____

_____

_____

_____

_____

In case of emergency, contact (specify someone not living in your household):_____

Relationship to patient_____ **Home phone**_____ **Cell phone**_____

I understand that accurate information is required for safe and efficient treatment and have answered the above questions to the best of my ability. If more information is required you have permission to request further information from the appropriate health care provider. I give permission to the doctor or authorized staff to take x-rays, photographs, models or other diagnostic tools to aid in determining my dental needs. I also give permission to perform all recommended treatment that is mutually agreed upon. I fully understand that some dental treatment embodies certain risks. I agree to be responsible for payment of all services rendered on my behalf. I understand that payment is due at the time of treatment unless specific prior arrangements have been made. In the event that payments are not received by the agreed upon dates a service charge may be added to my account.

Signed_____ **Date**_____