Medical History

Have you ever had any of the following? (circle the ones that apply):

Heart Problems/Shortness of breath
Mitral Valve Prolapse
Heart Pacemaker
High Blood Pressure
Low Blood Pressure
Circulatory Problems
Nervous Problems
Radiation Treatment
Chemotherapy
Artificial Heart Valve or Joints
Kidney Problems
Back Problems
Diabetes
Respiratory Disease
Latex Sensitivity
Swollen Neck Glands
Sinus Problems
Stroke
Drug Addiction
Hemophilia
Neurological Disorders
Asthma

Epilepsy
Headaches
Hepatitis, Jaundice or Liver Disease
Cancer
Psychiatric Care
Chronic Diarrhea
Allergies to Anesthetics
Allergies to Medicine or Drugs
Thyroid Problems
General Allergies
Blood Disease
Arthritis
Contact lenses
Glaucoma
Special Diet
Rheumatic Fever
HIV/AIDS or Other Immunosuppressive Disorders
Ulcer
Venereal Disease
Cold Sores/Fever Blisters
Fainting or Dizzy Spells

Have your even taken any of the following medication?
_____ Residronate (Actonel) _____ Tiludronate (Skelid) _____ Pamidronate (Aredia)
_____ Etidronate (Didronel) _____ Alendronate (Fosamax) _____ Zoledronate (Zometa)

Do you use Tobacco? Yes No If yes, how much? ____

Do you have any drug allergies or have you ever had an adverse reaction to any medication? If so, what ____________
____

Have you ever responded adversely to medical or dental treatment?____

Are you taking any medication at this time?________ If so, what____

Are you under the care of a physician? Yes No For what conditions?_________________________________

(Women) Do you suspect that you are pregnant? Yes No Are you nursing? Yes No

Is there anything else we should know about your medical history?____

I authorize the use of my study models and/or photographs and videos for lectures or publications by Dr. Richard Champagne. ?
Yes No

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date__________________________________ Signature____

Date__________________________________ Dr.'s Signature_______________________________________