Welcome to
Dr. David R. Bowser III
Cosmetic & Family Dentistry

Medical History Update

Patient Name: _____

Date of Birth: _____

Today's Date: _____

Patient Medical History Primary Care Physician _____

_____

Please check if you have ever had any of the following:

____ Heart Disease	____ Anemia	____ Thyroid Disease
____ Heart Murmur	____ Liver Disease	____ High Blood Pressure
____ Heart Attack	____ Hepatitis	____ Low Blood Pressure
____ Chest Pain (Angina)	____ Bleed Easily	____ Stroke
____ Congenital Heart Defect	____ Jaundice	____ Stomach Ulcer/Problems
____ Rheumatic Fever	____ HIV/AIDS	____ Radiation Therapy
____ Mitral Valve Prolapse	____ Glaucoma	____ Cancer
____ Shortness of Breath	____ Kidney Disease	____ Recent Weight Loss
____ Sexually Transmitted Disease	____ Sinusitis	____ Swelling of Hands & Feet
____ Psychiatric Treatment	____ Diabetes	____ Respiratory Problems
____ Fainting Spells/ Dizziness	____ Convulsions	____ Tuberculosis
____ Asthma	____ Epilepsy	____ Allergies? To what? _____
____ Joint Replacement or Implant	____ Other _____	_____

____ Have you ever had any serious illness other than above?
Please explain: _____

____ Are you under the care of a physician at the present time?
Why? _____

please list all medications you are currently taking: _____ _____
_____ _____ _____ _____ _____

____ Are you/ have you ever taken any medication to treat osteoporosis such as Boniva, Fosamax, Reclast, or Zometa?

____ Have you ever had a bad reaction to local anesthetic?
Please explain: _____

____ Have you ever had a bad reaction to any other drug?
Please explain: _____

____ Have you ever had any operations? What/when? _____
_____

____ Female: Are you now pregnant? What month? _____

To the best of my knowledge, the above confidential information is true.

Signature _____ Date _____