Cornerstone Dental of Green Brook
314 US HWY 22 West, Ste. D
Green Brook, NJ 08812

Patient Name: _____DOB_____ MEDICAL HISTORY

1. Physician's Name: _____ Phone: ( ) _____
   Have you had any medical care within the past two years? ..... **Yes or No**
   If Yes, describe: _____
2. Are you currently taking any medications, drugs, pill or herbal remedies? ..... **Yes or No**
   If Yes, please list: _____
3. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or similar drugs?..... **Yes or No**
4. Are you aware of any allergy to any substance or medication: **Yes or No** If Yes, please list: _____
5. Have you been a patient in the hospital during the past five years? ..... **Yes or No**
6. Indicate which of the following you have had, or have at present. Circle Yes or No to each item

Heart Surgery, Disease, or Attack: **Yes or No**	Kidney Trouble ..... **Yes or No**	Radiation Therapy .....**Yes or No**
Chest Pain ..... **Yes or No**	Ulcers .....**Yes or No**	Chemotherapy ..... **Yes or No**
Congenital Heart Disease..... **Yes or No**	Diabetes ..... **Yes or No**	Tumors /Cancer ..... **Yes or No**
Heart Murmur ..... **Yes or No**	Thyroid Problems ..... **Yes or No**	Hepatitis A, B, or C ..... **Yes or No**
High/Low Blood Pressure ..... **Yes or No**	Glaucoma .....**Yes or No**	Venereal Disease ..... **Yes or No**
Mitral Valve Prolapse ..... **Yes or No**	Contact Lenses ..... **Yes or No**	AIDS/HIV Positive ..... **Yes or No**
Artificial Heart Valve/Pacemaker... **Yes or No**	Emphysema ..... **Yes or No**	Cold Sores/Fever Blisters..... **Yes or No**
Rheumatic Fever ..... **Yes or No**	Tuberculosis ..... **Yes or No**	Hemophilia ..... **Yes or No**
Arthritis/Rheumatism ..... **Yes or No**	Asthma ..... **Yes or No**	Sickle Cell Disease ..... **Yes or No**
Cortisone Medicine .....**Yes or No**	Hay Fever/Allergy/Hives **Yes or No**	Bruise Easily ..... **Yes or No**
Liver Disease/Yellow Jaundice..... **Yes or No**	Latex Sensitivity.....**Yes or No**	Stroke ..... **Yes or No**
Artificial Joints (Hip, Knee, etc.).... **Yes or No**	Sinus Trouble .....**Yes or No**	Neurological Disorders.....**Yes or No**
Epilepsy or Siezures.....**Yes or No**	Fainting or Dizzy Spells ...**Yes or No**	Nervous/Anxious ..... **Yes or No**

7. Do you have or have you had any disease, condition, or problem not listed? .....**Yes or No**
8. Women: Are you pregnant or think you could be pregnant? **Yes ___ Months or No** Nursing? **Yes or No**
9. Do you use birth control prescriptions? ..... **Yes or No**

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature _____ Date _____

History Review

Dentist Signature _____ Date _____