Dr. Leonard F. Anglis   Implant Dentistry

Lowell   Crown Point   Michigan City

Medical History Form

Date _____________________

Name __________________________________ Home Phone ________________________

Address __________________________________ Cell Phone _________________________

Marital Status _______________ Spouse's Name _________________________________

Your Place of employment ____

Work Address ___________________________________ Work Phone __________________

Date of Birth_______________ Occupation _______________________________________

Emergency Contact Name and Phone number _______________________________________

Your Physician Name ___________________________ Phone number ___________________

Date of last visit to physician ____________ Are you currently being treated? Y ___ N ___

Are you currently taking any medications? (This includes over-the-counter medications as well as prescriptions) Y___ N ___ If yes, please give details _______________________________

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Are you taking any vitamins or supplements? If yes, what? _____________________________

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Are you allergic to any medications? Y ___ N ___ If yes, what? _________________________

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Have you ever taken Fosamax, Actonel, Boniva or any other bisphosphonate? Y ___ N ___

Any recent serious illness? If yes, please explain.______________________________________

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Do you have a history of any of the following? If so, please give details.

Y___ N___ Arthritis ____

Y___ N___ Asthma ____

Y___ N___ Allergic to Anesthetic ____

Y___ N___ Bleeding Disorders ____

Y___ N___ Heart Condition ____

Y___ N___ Diabetes ____

Y___ N___ Stroke ____

Y___ N___ Hepatitis ____

Y___ N___ AIDS/HIV ____

Y___ N___ Artificial Joints ____

Y___ N___ Heart Valve Problems ____

Y___ N___ Epilepsy ____

Y___ N___ Emotional Stress ____

Y___ N___ High Blood Pressure ____

Y___ N___ Rheumatic Fever ____

Y___ N___ Other Condition (s) ____

Signature: ____