Dr. Leonard F. Anglis Implant Dentistry
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 _____
_____
Are you taking any vitamins or supplements? If yes, what? _____
_____
Are you allergic to any medications? Y ___ N ___ If yes, what? _____
_____
Have you ever taken Fosamax, Actonel, Boniva or any other bisphosphonate? Y ___ N ___
Any recent serious illness? If yes, please explain._____
_____
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: _____