YOUR PERFECT SMILE
Cosmetic and Family Dentistry
1939 Lawrence Road Kemah, Texas 77565
Telephone: (281) 538-9300

MEDICAL HISTORY

Physician's Name____ Date of Last Visit___________________________

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine), and Redux (dexfenfluramine.) ☐Yes ☐No

List any operations and dates____

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Have you ever had a blood transfusion? ☐Yes ☐No If yes, give approximate dates___________________________________

(Women) Are you pregnant/trying to get pregnant? ☐Yes ☐No Nursing? ☐Yes ☐No Taking birth control pills? ☐Yes ☐ No

Check (✓) if you have or have had any of the following:

☐AIDS/HIV Positive
☐Alzheimer's disease
☐Anaphylaxis
☐Anemia
☐Angina
☐Arthritis, Rheumatism
☐Artificial Heart Valve
☐Artificial Joint
☐Asthma
☐Back Problems
☐Blood Disease
☐Blood Transfusion
☐Breathing Problem
☐Bruise Easily
☐Cancer
☐Chemical Dependency
☐Chemotherapy
☐Chest Pains
☐Circulatory Problems
☐Cold Sores/Fever Blisters
☐Congenital Heart Disorder
☐Convulsions
☐Cortisone Treatments
☐Diabetes
☐Drug Addiction
☐Easily Winded
☐Emphysema
☐Epilepsy or Seizures
☐Excessive Bleeding
☐Excessive Thirst
☐Fainting Spells/Dizziness
☐Frequent Cough
☐Frequent Diarrhea
☐Frequent Headaches
☐Genital Herpes
☐Glaucoma
☐Hay Fever
☐Headaches
☐Heart Attack/Failure
☐Heart Murmur
☐Heart Pace Maker
☐Heart Trouble/Disease
☐Hemophilia
☐Hepatitis A
☐Hepatitis B or C
☐Herpes
☐High Blood Pressure
☐Hives or Rash
☐Hypoglycemia
☐Irregular Heartbeat
☐Jaw Pain
☐Kidney Problems/Disease
☐Leukemia
☐Liver Problems/Disease
☐Low Blood Pressure
☐Lung Disease
☐Mitral Valve Prolapse
☐Parathyroid Disease
☐Psychiatric Care
☐Radiation Treatment
☐Recent Weight Loss
☐Renal Dialysis
☐Respiratory Disease
☐Rheumatic Fever
☐Rheumatism
☐Scarlet Fever
☐Shingles
☐Shortness of Breath
☐Sickle Cell Disease
☐Sinus Trouble
☐Skin Rash
☐Spina Bifida
☐Stomach/Intestinal Disease
☐Stroke
☐Swelling of Limbs
☐Thyroid Problems/Disease
☐Tobacco Habit
☐Tonsillitis
☐Tuberculosis
☐Tumors or Growths
☐Ulcer
☐Venereal Disease/STD
☐Yellow Jaundice

MEDICATIONS

List medications you are currently taking:

____

____

Pharmacy Name________________________________

Phone (___)___________________________________

ALLERGIES

☐Aspirin
☐Barbiturates (Sleeping pills)
☐Codeine
☐Local Anesthetic
☐Penicillin
☐Sulfa
☐Latex_____________
☐Other_____________
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SIGNATURE

The above information is accurate and complete to the best of my knowledge. 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____