

Family Doctor's Name _____ Phone# _____

Are you now taking any medication, drugs or pills? _____ Yes / No

If yes, please list: taking: _____ for: _____
taking: _____ for: _____
taking: _____ for: _____

Are you a smoker? Yes No How many per day? _____

Are you allergic or have you reacted adversely to any of the following medications? Yes / No

- Aspirin Latex Local Anesthetic
- Codeine Penicillin Other Antibiotics

Are you aware of being allergic to any other medications or substances? Yes / No
which one?: _____

Please answer yes or no if you have had or have any of the following:

Yes No

- Heart Failure
- Heart Disease or Attack
- Angina
- Heart Murmur
- Rheumatic Fever
- Congenital Heart Lesions
- Artificial Heart Valve
- Heart Pacemaker
- Artificial Joints (Hip, Knee)
- Anemia
- Stroke
- Kidney Disease
- COPD (Emphysema)
- Tuberculosis (TB)

Yes No

- Asthma
- Hay Fever
- Allergies or Hives
- Thyroid Disease
- Arthritis
- Glaucoma
- A.I.D.S./HIV
- Anorexia/Bulimia
- Hepatitis A
- Hepatitis B, C, D, etc.
- Liver Disease
- Drug Addiction
- Hemophilia
- Cold Sores

Yes No

- Epilepsy or Seizures
- Psychiatric Treatment
- Bruise Easily
- Family History of Gum Disease
- Family History of Diabetes
- Family History of Cancer

Do you have high or low blood pressure? _____ Yes / No

Have you had pains in the chest or shortness of breath? _____ Yes / No

Do your ankles ever swell? _____ Yes / No

Have you ever had or do you have diabetes? _____ Yes / No

how is it controlled? _____

Have you ever had a tumor or cancer? _____ Yes / No

how was it treated? _____

Have you had any operations? _____ Yes / No

what kind? _____

Have you ever had a blood transfusion? _____ Yes / No

what year? _____

Are you on a special diet? _____ Yes / No

for what purpose? _____

Do you have a current medical problem not mentioned above _____ Yes / No

please list: _____

FOR WOMEN ONLY

Are you pregnant? Yes No If yes, what month? _____

Are you taking birth control pills Yes No

Do you have a history of previous miscarriages Yes No

<< Please Read >>

I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made.

Patient Signature: _____ Date: _____

Patient or Responsible Party: _____ Relationship to Patient: _____

