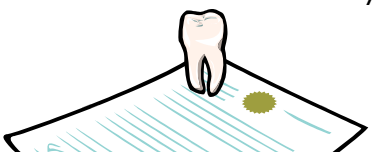
Patient Medical History



We Know How To Make You Smile

Dr. Andy Friedman DMD

Name_____ Date of Birth_____

Mailing Address_____

City:_____ State:_____ Zip:_____

Phone # we should have to contact you _____

Although dentists primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have or medication you may be taking, may have an important interrelation with dental treatment. ***Thank you for answering these important questions about your health.***

Are you under a physician's care now? ___ **Yes** ___ **No** If yes, please explain_____

Have you ever been hospitalized or had a major operation**?**___ **Yes** ___ **No** If yes, please explain_____

Have you ever had a serious head or neck injury? ___ **Yes** ___ **No** If yes, please explain_____

Are you taking any medication, pills or drugs (prescription or over-the-counter**)**___ **Yes** ___ **No** If yes, please list them

_____

Do you take, or have you taken Phen-Fen or Redux? ___ **Yes** ___ **No** If yes, please explain_____

Are you on a special diet**?** ___ **Yes** ___ **No** If yes, please explain_____

Do you use tobacco**?**___ **Yes** ___ **No** Do you used controlled substances**?**___ **Yes** ___ **No**

Do you require pre-medication for dental treatment? ____Yes ___No

EMERGENCY INFO

Emergency Contact _____

Emergency Phone_____

Family Doctor Info

Physician_____

Address_____

Phone_____

Women: Are you

____Pregnant/Trying to get pregnant? ____Nursing?

____Taking oral contraceptives?

Are you allergic to:

___ Aspirin ___ Penicillin ___ Codeine ___ Acrylic

___ Metal ___ Latex ___ Local Anesthetics

Other?_____

(please list)

Do you have, or have you had, any of the following?

- □ AIDS/HIV positive
- □ Alzheimer's Disease
- □ Anaphylaxis
- □ Anemia
- □ Angina
- □ Arthritis/Gout
- □ Artificial Heart Valve
- □ Artificial Joint
- □ Asthma
- □ Blood Disease
- □ Blood Transfusion
- □ Breathing Problem
- □ Bruise Easily
- □ Cancer
- □ Chemotherapy
- □ Chest Pains
- □ Cold Sores/Fever Blisters
- □ Congenital Heart Disorder
- □ Convulsions
- □ Cortisone Medicine
- □ 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
- □ 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
- □ Kidney Problems
- □ Leukemia
- □ Liver Disease
- □ Low Blood Pressure
- □ Lung Disease
- □ Mitral Valve Prolapse
- □ Pain in Jaw Joints
- □ Parathyroid Disease
- □ Psychiatric Care
- □ Radiation Treatments
- □ Recent Weight Loss
- □ Renal Dialysis
- □ Rheumatic Fever
- □ Rheumatism
- □ Scarlet Fever
- □ Shingles
- □ Sickle Cell Disease
- □ Sinus Trouble
- □ Spina Bifida
- □ Stomach/Intestinal Disease
- □ Stroke
- □ Swelling of Limbs
- □ Thyroid Disease
- □ Tonsilitis
- □ Tuberculosis
- □ Tumors or Growths
- □ Ulcers
- □ Venereal Disease
- □ Yellow Jaundice

Have you ever had any serious illness not listed above? ___ **Yes** ___ **No** (please explain)_____

_____

_____

Comments _____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing in-correct information can be dangerous to my health or that of the patient. It is my responsibility to keep the dental office informed of medical status and update changes when they occur.

Signature of Patient, Parent or Guardian_____ Date_____