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Medical Information

Today's Date: ____/____/____

Patient Information

Medical Alert: ____________

Name: ____________ Age: ______ Height: ______ Weight: ______

What is the primary reason for today's visit? ____________

Current Physician: Dr. ____________ Phone: ( ) ____________ Medical Specialty: ____________

Current Medications: ____________
(Attach list if appropriate)

Hospitalization, or outpatient treatment in the last ten years? ____________ ☐ Yes ☐ No

(Description of treatment) ____________

Please describe if you suffer from (or have suffered) the following:

Prolonged Bleeding or Bruising: ☐ Yes ☐ No ____________

Delayed Healing: ☐ Yes ☐ No ____________

Severe Allergic Reaction: ☐ Yes ☐ No ____________

Sensitivity or Reaction To:

Latex Contact: ☐ Yes ☐ No Penicillin: ☐ Yes ☐ No

Codeine: ☐ Yes ☐ No Dental Novocaine: ☐ Yes ☐ No

Artificial Heart Valves and/or Artificial Joints? ☐ Yes ☐ No

High Blood Pressure? ☐ Yes ☐ No Recent Blood Pressure Reading ______/______

Diabetes? ☐ Yes ☐ No Insulin Required? ☐ Yes ☐ No

HIV Positive? ☐ Yes ☐ No AIDS? ☐ Yes ☐ No

(Women) Are You Pregnant? ☐ Yes ☐ No When is your "Delivery Date"? ____/____/____ Month Day Year

Have you ever had any of the following illnesses?

Hepatitis A ☐ Yes ☐ No ______ When *(Date)*

Hepatitis C ☐ Yes ☐ No ______ When *(Date)*

Hepatitis B ☐ Yes ☐ No ______ When *(Date)*

Tuberculosis ☐ Yes ☐ No ______ When *(Date)*

Sexually Transmitted Disease ☐ Yes ☐ No ______ When *(Date)*

(Type(s) of S.T.D.) ____________

Heart Disease ☐ Yes ☐ No ______ When *(Date)*

Asthma/Emphysema ☐ Yes ☐ No ______ When *(Date)*

Blood Transfusion ☐ Yes ☐ No ______ When *(Date)*

Kidney Disease ☐ Yes ☐ No ______ When *(Date)*

Other ☐ Yes ☐ No ______ When *(Date)*

Epilepsy/Seizures ☐ Yes ☐ No ______ When *(Date)*

Arthritis ☐ Yes ☐ No *(Type)* ______

Jaundice ☐ Yes ☐ No ______ When *(Date)*

Heart Disease ☐ Yes ☐ No ______ When *(Date)*

Anemia ☐ Yes ☐ No ______ When *(Date)*

Stroke ☐ Yes ☐ No ______ When *(Date)*

Sinus Infection ☐ Yes ☐ No ______ When *(Date)*

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Dental Information

Have you experienced any of the following? *(Please date and note prior treatment.)*

Periodontal (Gum) Disease ☐ Yes ☐ No ______ When *(Date)*

TMJ Dysfunction, Jaw Noise, Popping, or Clicking ☐ Yes ☐ No ______ When *(Date)*

Prolonged mouth breathing ☐ Yes ☐ No ______ When *(Date)*

If you could change *anything* about your teeth or smile, what would it be? ____________

★ ____________ Patient Signature, or Parent *(If Patient is a Minor)* ____________ Date