Smiles 'R' Us

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Medical History

Name: E-mail: Phone:

Are you in good health? ○ Yes ○ No Height: Weight:

Has there been any change in your general health? ○ Yes ○ No

Your last physical examination was on: Are you now under the care of a physician? ○ Yes ○ No

Name of your physician:

Address of your physician:

Have you ever had a serious illness or operation? ○ Yes ○ No

Have you been hospitalized with any of the following within the last 5 years?

Do you have a persistent cough or cough up blood? ○ Yes ○ No Low/High blood pressure(circle one) ○ Yes ○ No

Venereal Disease ○ Yes ○ No AIDS or HIV+ ○ Yes ○ No

Other:

Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? ○ Yes ○ No

Do you bruise easily? ○ Yes ○ No

Have you ever required a blood transfusion ○ Yes ○ No

If yes, explain the circumstances:

Do you have any blood disorder such as anemia? ○ Yes ○ No

Have you had surgery or x-ray treatment for a tumor, growth or other condition of your mouth or lips? ○ Yes ○ No

Medications

Are you taking any drug or medication? ○ Yes ○ No

If yes, what?

Are you taking any of the following?

Antibiotics or sulfa drugs ○ Yes ○ No Tranquilizers ○ Yes ○ No

Cortisone (steroids) ○ Yes ○ No

Medicine for high blood pressure ○ Yes ○ No

Insulin, Tolbutamide (Orinase) or similar drug ○ Yes ○ No

Digitalis or drugs for heart trouble ○ Yes ○ No

Osteoporosis Drugs (Fosamax, Aredia, Zometa etc.) ○ Yes ○ No

Aspirin ○ Yes ○ No

Anticoagulants (blood thinners such as Coumadin, Plavix etc) ○ Yes ○ No

Nitroglycerin ○ Yes ○ No

Any natural product, herbal supplement or homeopathic remedy? ○ Yes ○ No

Chemotherapy Drugs ○ Yes ○ No

Fen-Phen (now or in the past) or related drug such as Ionimin, Adipex, Phentermine, Fastin, Pondimin (Fenfluramine), and Redux (dexfenfluramine) ○ Yes ○ No

Oral Contraceptives ○ Yes ○ No

If yes, what are you using?

Other:

Habits

Do you smoke? ○ Yes ○ No

If yes, how much?

Do you drink alcoholic beverages? ○ Yes ○ No

Do you take any recreational drugs? ○ Yes ○ No

Do you have any of the following?

Cardiac pacemaker ○ Yes ○ No

A removable dental appliance ○ Yes ○ No

Implants/Artificial prosthesis (Knee joints, elbow pins etc) ○ Yes ○ No

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

Rheumatic fever or rheumatic heart disease ○ Yes ○ No

Hepatitis, jaundice, or liver disease ○ Yes ○ No

Heart Murmur or mitral valve prolapse ○ Yes ○ No

Congenital heart lesions ○ Yes ○ No

Convulsions/epilepsy ○ Yes ○ No

Stroke ○ Yes ○ No

Asthma or hay fever ○ Yes ○ No

Hives or skin rash ○ Yes ○ No

Fainting spells or seizures ○ Yes ○ No

Arthritis ○ Yes ○ No

Inflammatory rheumatism (painful, swollen joints) ○ Yes ○ No

Stomach ulcers ○ Yes ○ No

Kidney trouble ○ Yes ○ No

Tuberculosis ○ Yes ○ No

A tumor or growth ○ Yes ○ No

Radiation therapy or chemotherapy ○ Yes ○ No

Thyroid trouble ○ Yes ○ No

Bleeding tendency /abnormal bleeding ○ Yes ○ No

Are you immunosuppressed? Possibly from transplant surgery ○ Yes ○ No

Cardiovascular disease (heart trouble, heart attack, coronary occlusion, high blood pressure, arteriosclerosis, stroke)

○ Yes ○ No

Do you have pain in the chest upon exertion? ○ Yes ○ No

Are you ever short of breath after mild exercise? ○ Yes ○ No

Do you get short of breath when you lie down or do you require extra pillows when you sleep? ○ Yes ○ No

Diabetes ○ Yes ○ No

Do you have to urinate (pass water) more than six (6) times a day? ○ Yes ○ No

Are you thirsty much of the time? ○ Yes ○ No

Does your mouth frequently become dry? ○ Yes ○ No

Allergy

Are you allergic or have you reacted adversely to:

Local anesthetic ○ Yes ○ No

Barbiturates, sedatives, or sleeping pills ○ Yes ○ No

Sulfa Drugs ○ Yes ○ No

Codeine ○ Yes ○ No

Valium or other tranquilizer ○ Yes ○ No

Aspirin ○ Yes ○ No

Iodine ○ Yes ○ No

Latex ○ Yes ○ No

Penicillin or other antibiotics (such as amoxicillin, clindamycin, erythromycin, Keflex etc) ○ Yes ○ No

Other:

Have you had any serious trouble associated with previous dental treatment? ○ Yes ○ No

If yes, explain:

For Women Only

Are you pregnant or could you be? ○ Yes ○ No

If yes, when are you due?

Are you nursing? ○ Yes ○ No

Are you taking oral contraceptives? ○ Yes ○ No

If yes, what?

Comments:

I certify to the best of my knowledge that the above information is correct and that if there are any changes in the above, I agree to notify my dentist or my surgeon before my next visit.

Patient's Signature:

Date:

Guardian's Signature:

Date:

Doctor's Signature:

Date: