Patient Medical Information

Name_____
(Last) (First) (M.I.)

Family Physician_____Physician's Phone #_____
When was your last visit to a physician and why?_____

When was your last dental visit?_____What was done?_____
Present complaint or request_____
Has the patient had or ever been told (he, she) has had:

1) An allergic reaction to any drugs……□Y□N
   If yes, please list_____
2) A reaction to an anesthetic injection……□Y□N
3) Excessive or prolonged bleeding……□Y□N
4) Slow healing of a wound or incision……□Y□N
5) Please circle any of the following you have ever had:

Allergies	liver disorders	diabetes	venereal disease	cancer-any type
Jewelry allergy	bleeding disorders	respiratory problems	gonorrhea	radiation treatment
Nickel allergy	rheumatic fever	asthma	frequent headaches	prosthetic treatment
Anemia	heart murmur	hepatitis type_____	earaches	nervous disorder
Tuberculosis	heart disease	glaucoma	high/low blood press	HIV+
Kidney disorders	heart surgery	epilepsy	facial muscle pain	other_____

6) Any other general health conditions that might have a bearing on dental care _____
   _____
7) If female: Are you pregnant? □Y□N Due Date_____
8) Do you take Birth Control Pills? □Y□N
9) List any recent medications:

(Medication)		(Reason for taking)
_____	→	_____
_____	→	_____
_____	→	_____
_____	→	_____
_____	→	_____
_____	→	_____
_____	→	_____
_____	→	_____
_____	→	_____

10) Have you ever been exposed to HIV? □Y□N
    If yes, please explain_____
11) Any other blood conditions?_____

Signature_____Date_____
(Patient or Guardian/Presenting Parent or Minor)