19th Avenue Dental

Medical History

Do you have a personal physician?..☐Yes ☐No
Physician's
Name____
Phone#(________)________________________Date of last visit____________________
Your current health is..☐Good ☐Fair ☐Poor
Are you currently receiving treatment by a physician?........................☐Yes ☐No
Please explain____
Do you smoke or use tobacco products?...☐Yes ☐No
Are you taking any prescriptions/over-the-counter drugs?..................☐Yes ☐No
If yes, please list each one____
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For Women: Are you currently taking birth control pills?.................☐Yes ☐No
Are you pregnant?..☐Yes ☐No
Week#_____________Are you nursing?...☐Yes ☐No

Do you have or ever had any of the following?

Y	N	Anemia/Radiation Treatment	Y	N	Heart Surgery/Pacemaker
Y	N	Artificial Bone/Joints	Y	N	Hemophilia/Abnormal Bleeding
Y	N	Artificial Valves	Y	N	Hepatitis
Y	N	Asthma	Y	N	High/Low Blood Pressure
Y	N	Arthritis	Y	N	HIV+/AIDS
Y	N	Blood Transfusion	Y	N	Hospitalized for any reason
Y	N	Cancer/Chemotherapy	Y	N	Kidney Problems
Y	N	Congenital Heat Defect	Y	N	Mitral Valve Prolapse
Y	N	Diabetes	Y	N	Psychiatric Condition
Y	N	Difficulty Breathing/Emphysema	Y	N	Rheumatic/Scarlet Fever
Y	N	Drug/Alcohol Abuse	Y	N	Severe/Frequent Headaches
Y	N	Epilepsy/Seizures/Fainting Spells	Y	N	Shingles
Y	N	Fever Blisters/Herpes	Y	N	Sinus Problems
Y	N	Glaucoma	Y	N	Tuberculosis(TB)
Y	N	Heart Attack/Stroke	Y	N	Ulcers/Colitis
Y	N	Heart Murmur	Y	N	Venereal Disease

Please list any serious condition(s) you have either had or have not listed above:_______
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Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Latex
Y	N	Codeine	Y	N	Penicillin
Y	N	Dental Anesthetics	Y	N	Sedatives
Y	N	Erythromycin	Y	N	Sulfa Drugs
Y	N	Jewelry/Metals	Y	N	Tetracycline

Please list any drugs that you are allergic to not listed above:______________________
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Today's Date__________________Patient's Signature______________________________
If patient is minor, guardian or parent must sign

Today's Date______________Provider Signature___________________________________