

# AllSmiles Dental Care PLLC

1043 Oaklawn Drive, Culpeper, VA 22701  
540-829-9922

## MEDICAL HISTORY

Patient Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

Have you been under your physician's care in the last 2 years? Yes No

If yes, for what? \_\_\_\_\_

Have you been hospitalized in the last 5 years? Yes No For: \_\_\_\_\_

List medications/drugs taken in the last 2 years. \_\_\_\_\_

List all medications/drugs/herbs/aspirin, etc. and dosages taken now. \_\_\_\_\_

Have you ever taken prescriptions for weight loss such as Fen-Phen, Pondimin, or Redux?

Yes No Were you examined for heart problems afterward? Yes No

Are you allergic to any medication/substance? Yes No

List: \_\_\_\_\_

### Have you had or do you now have:

Heart (surgery, disease, attack)	Y N	Ulcers	Y N	Hepatitis A B C (circle)	Y N
Chest pain	Y N	Diabetes	Y N	Venereal Disease	Y N
Congenital Heart Disease	Y N	Glaucoma	Y N	AIDS	Y N
Heart Murmur	Y N	Contact lenses	Y N	HIV positive	Y N
High Blood Pressure	Y N	Emphysema	Y N	Blood Transfusion	Y N
Prolapsed Mitral Valve	Y N	Chronic cough	Y N	Hemophilia	Y N
Pacemaker	Y N	Tuberculosis	Y N	Sickle Cell Anemia	Y N
Artificial Heart Valve	Y N	Asthma	Y N	Easy bruising	Y N
Rheumatic Fever	Y N	Hay Fever	Y N	Liver Disease	Y N
Thyroid Problems	Y N	Allergies/Hives	Y N	Jaundice	Y N
Arthritis/Rheumatism	Y N	Sinus Problems	Y N	Cold sore/Fever blister	Y N
Stroke	Y N	Latex Sensitivity	Y N	Neurological Disorders	Y N
Joint Replacement	Y N	Radiation Therapy	Y N	Epilepsy/Seizures	Y N
Kidney Problems	Y N	Chemotherapy	Y N	Nervous/Anxious	Y N
Restricted Diet	Y N	Tumors	Y N	Psychiatric/	
Cortisone Medication	Y N	Swollen ankles	Y N	Psychological Care	Y N

Do you need more than 2 pillows to sleep? Yes No

Have you gained or lost more than 10 pounds in the past year? Yes No

Do you have any other problem or disease? If so, what? \_\_\_\_\_

**Women:** Are you pregnant? Yes No How many months? \_\_\_\_\_ Nursing? Yes No

Do you think you may be pregnant? Yes No Are you trying to become pregnant? Yes No

**Women:** Do you use birth control medications? Yes No

Signature

Date