All Smiles Dental Care, PLLC

MEDICAL HISTORY

Patient Name: ______________________________ DOB:_____/______/_________

Physician's Name: ____________________________Physician's Phone (_____)_______________

Physician's 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? Y N For: ______________________________

List medications/drugs taken in the last 2 years_______________________________________

List all medications/drugs/herbs/aspirin, etc. and dosages taken now: ______________________

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Have you ever taken or are you currently taking prescription medication for the treatment of osteoporosis such as Actonel, Boniva or Fosamax ? Yes No

Are you allergic to any medication/substance? Yes No List: ______________________________

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Have you had or do you now have:

Heart (surgery, disease, attack)	Y	N	Diabetes	Y	N	Hepatitis A B C (circle)	Y	N
Chest Pain	Y	N	Insulin Pump	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
Osteoporosis	Y	N	Tumors	Y	N	Psychiatric/Psychological	Y	N
Cortisone Medication	Y	N	Swollen ankles	Y	N	Restricted Diet	Y	N
Ulcers	Y	N						

Do you need more than 2 pillows to sleep? Y N

Have you gained or lost more than 10 pounds in the past year? Y N

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

Women: Are you pregnant? Y N How many months? ____________ Nursing? Y N

Do you think you may be pregnant? Y N Are you trying to become pregnant? Y N

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Signature Date