DOWNTOWN DT DENTAL - MEDICAL INFORMATION

Family Physician: _____ Phone Number:_____

Are you under the care of a physician or specialist for any medical condition? If so, what?
_____

Please list any medications, non prescription drugs, herbal supplements, and vitamins you are taking. Please include dosage and why they have been prescribed. _____
_____

Have you ever been told to take antibiotics before dental treatment? □ Yes □ No

Do you smoke or chew tobacco? □ Yes □ No If Yes, how often?_____
Have you ever smoked or chewed tobacco? Yes □ No □
If Yes, for how long? _____When did you quit?_____

Do you have or have you ever had any of the following?

□ an allergic or unusual reaction to:
- □ pain medication (aspirin, ibuprofen, acetaminophen)
- □ penicillin or other antibiotic
- □ sedatives or sleeping bills
- □ codeine or other narcotics
- □ local anaesthetic
- □ metals, plastic, latex
- □ other _____

□ Heart Problems:
- □ infective endocarditis
- □ chest pain/angina
- □ heart attack
- □ heart surgery
- □ pacemaker or implantable defibrillator
- □ artificial heart valves
- □ congenital heart disease
- □ other _____

□ Respiratory (Lung) Problems:
- □ asthma
- □ tuberculosis
- □ shortness of breath
- □ sleep breathing disorder
- □ emphysema/COPD
- □ other_____

□ Blood Pressure Problems:
- □ high
- □ low

□ Infectious Diseases
- □ Hepatitis A, B, or C
- □ HIV/AIDS
- □ Sexually Transmitted Disease

□ Herpes or Cold Sores
- □ other_____

□ Cancer-what type?_____
- □ radiation
- □ chemotherapy

□ frequent headaches, migraines
□ glaucoma
□ neurologic disorders
□ depression
□ bleeding problems hemophilia
□ anemia
□ stroke
□ artificial prosthesis or joint(s)
□ seizures or epilepsy
□ fainting
□ kidney disease
□ liver disease
□ thyroid disease
□ high cholesterol
□ diabetes
□ digestive disorders, gastric reflux, ulcer, celiac
□ bulimia
□ osteoporosis, osteopenia, arthritis
□ autoimmune disease
□ head and neck injuries
□ anxiety
□ psychiatric care
□ ADD/ADHD

Are you a woman who is: pregnant? □ Yes □ No If yes, when is your due date?_____
- □ nursing?
- □ planning a pregnancy?
- □ taking birth control pills?

Do you have any other condition or disease not listed? If so, what?_____

Patient Signature:_____Date:_____