kimberlysmiles
cosmetic&generaldentistry
& associates

# Medical History

Patient _____

Physician _____ Date Of Last Visit _____

Please list all medications you are currently taking with dosage:

_____

_____

List all allergies:

_____

Are you pregnant? □ Yes □ No Nursing? □ Yes □ No Taking birth control pills? □ Yes □ No

Indicate which of the following you have had, or have at present? (Check all that apply).

| | | | |
|---|---|---|---|
| □ AIDS | □ Circulatory Problems | □ Hepatitis | □ Scarlet Fever |
| □ Allergies or Hives | □ Cold Sores | □ High Blood Pressure | □ Shortness of Breath |
| □ Anemia | □ Cortisone Treatments | □ HIV Positive | □ Sinus Problems |
| □ Anxiety Problmes | □ Cough, Persistent | □ Jaw Pain | □ Skin Rash |
| □ Arthritis, Rheumatism | □ Cough up blood | □ Kidney Trouble | □ Stroke |
| □ Artificial Heart Valves | □ Diabetes | □ Latex Sensitivity | □ Swelling of Feet/Ankles |
| □ Artificial Joints | □ Epilepsy | □ Liver Disease | □ Thyroid Problems |
| □ Asthma | □ Fainting | □ Mitral Valve Prolapse | □ Tobacco Habit |
| □ Back Problems | □ Glaucoma | □ Neurological Problems | □ Tonsillitis |
| □ Blood Disease | □ Headaches | □ Pacemaker | □ Tuberculosis |
| □ Cancer | □ Heart Murmur | □ Psychiatric Care | □ Ulcers |
| □ Chemical Dependency | □ Heart problems | □ Radiation Treatment | □ Venereal Disease |
| □ Chemotherapy | □ Hemophilia | □ Rheumatic Fever | |

□ Other: _____

_____

Please describe any positive responses from the list above:

_____

_____

Do you smoke? □ Yes □ No Describe _____

Do you use alcohol? □ Yes □ No Describe _____

Do you use recreational drugs? □ Yes □ No Describe _____

Have you had surgery or been hospitalized in the last 5 years? □ Yes □ No Describe

_____

_____

Dentist's Signature _____ Date: _____

History Review _____ History Review _____ History Review _____ History Review _____

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