WATERS FAMILY DENTISTRY

Patient Medical History: Please circle the appropriate answer for each question.

Patient Name: _____ DOB: _____

Are you under a physician's care now? YES/NO

If yes, for what condition(s)? _____

Have your ever been hospitalized or has a major operation? YES/NO

If yes, for what condition(s)? _____

Have you ever had a serious head or neck injury? YES/NO

If yes, _____

Are you taking any prescribed medication, pills, or drugs? YES/NO

If yes, please list medications: _____

_____

_____

Do you take, or have you taken Fen-Phen/Redux? YES/NO

Have you taken Fosamax, Boniva, Actonel, or any other
Medications containing bisphosphonates? YES/NO

Are you on a special diet? YES/NO

Do you use tobacco? YES/NO

Do you use a controlled substance(s)? YES/NO

If yes, please list: _____

ARE YOU ALLERGIC OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING?

-Aspirin	YES/NO	-Acrylic	YES/NO
-Penicillin	YES/NO	-Metal	YES/NO
-Codeine	YES/NO	-Latex	YES/NO
- Local Anesthetics	YES/NO	-Sulfa Drugs	YES/NO

-OTHER: _____

WOMEN ONLY:

Are you pregnant or trying to get pregnant? YES/NO

Are you nursing? YES/NO

Are you taking oral contraceptives? YES/NO

(CONTINUED ON BACK)

Patient Medical History: Please circle the appropriate answer for each question.

DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING?

AIDS/HIV Positive	YES/NO	Hepatitis A	YES/NO
Alzheimer's disease	YES/NO	Hepatitis B or C	YES/NO
Anaphylaxis	YES/NO	Herpes	YES/NO
Anemia	YES/NO	High Blood Pressure	YES/NO
Angina	YES/NO	High Cholesterol	YES/NO
Arthritis/Gout	YES/NO	Hives or Rash	YES/NO
Artificial Heart Valve	YES/NO	Hypoglycemia	YES/NO
Artificial Joint	YES/NO	Irregular Heartbeat	YES/NO
Asthma	YES/NO	Kidney Problems	YES/NO
Blood disease	YES/NO	Leukemia	YES/NO
Blood Transfusion	YES/NO	Liver Disease	YES/NO
Breathing Problems	YES/NO	Low Blood Pressure	YES/NO
Bruise Easily	YES/NO	Lung Disease	YES/NO
Cancer	YES/NO	Mitral Valve Prolapse	YES/NO
Chemotherapy	YES/NO	Osteoporosis	YES/NO
Chest Pains	YES/NO	Pain in Jaw Joints	YES/NO
Cold Sores/Fever Blisters	YES/NO	Parathyroid Disease	YES/NO
Congenital Heart Disorder	YES/NO	Psychiatric Care	YES/NO
Convulsions	YES/NO	Radiation Treatments	YES/NO
Cortisone Medications	YES/NO	Recent Weight Loss	YES/NO
Diabetes	YES/NO	Renal Dialysis	YES/NO
Drug Addiction	YES/NO	Rheumatic Fever	YES/NO
Easily Winded	YES/NO	Rheumatism	YES/NO
Emphysema	YES/NO	Scarlet Fever	YES/NO
Epilepsy or Seizures	YES/NO	Shingles	YES/NO
Excessive Bleeding	YES/NO	Sickle Cell Disease	YES/NO
Excessive Thirst	YES/NO	Sinus Trouble	YES/NO
Fainting Spells/Dizziness	YES/NO	Spina Bifida	YES/NO
Frequent Cough	YES/NO	Stomach/Intestinal Disease	YES/NO
Frequent Diarrhea	YES/NO	Stroke	YES/NO
Frequent Headache	YES/NO	Swelling of Limbs	YES/NO
Glaucoma	YES/NO	Thyroid Disease	YES/NO
Hay Fever	YES/NO	Tonsillitis	YES/NO
Heart Attack/Failure	YES/NO	Tuberculosis	YES/NO
Heart Murmur	YES/NO	Tumors or Growths	YES/NO
Heart Pacemaker	YES/NO	Ulcers	YES/NO
Heart Trouble/Disease	YES/NO	Venereal Disease	YES/NO
Hemophilia	YES/NO	Yellow Jaundice	YES/NO

Have you ever had any illness not listed above? YES/NO
If YES, please list: _____

AUTHORIZATION AND RELEASE: To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian: _____ Date:_____

Reviewed by Dr.: _____ Date:_____