Chavez Dental

MEDICAL HISTORY

Name ____

Your current health is:
- Excellent
- Good
- Fair
- Poor

Medical Doctor's name: ______________________________

Last Exam ________________

Are you currently under a physician's care?
- Yes , for what? ___________________________________
- No

Are you taking a prescription / over the counter drug? Y N

Please list them: _____________________________________

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Are you sensitive or allergic to the following ?
- NO KNOWN ALLERGIES
- Penicillin
- Aspirin
- Codeine
- Sulfa Drugs
- Latex
- Tetracycline
- Erythromycin
- Ibuprofen (Advil)
- Other: ____

Do you require ***pre-medication*** for Dental visits Y N

For Women: Are you taking birth control pills? Y N

Are you pregnant? Yes, how long ___________ No

Are you nursing? Yes No

I understand that the information I have given is correct and to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform the office of any changes to my medical status. I authorize the dentist and staff to perform any necessary dental services with my informed consent, that may be needed during diagnosis and treatment.

Signature: _______________________ **Date** _______

***Emergency Contact*: Person to contact outside of immediate family in case of emergency:**

Name: ______________________________________

Relationship to you ____________________________

Phone numbers Home:________________________

Cell: __________________________

Office: ________________________

Do you HAVE or have you EVER HAD any of the following

Please check **Y-Yes** or **N-No**

Y	N		Y	N	
		Anemia			Common Cold
		Hemophilia			Asthma/Hay-fever
		Bruise easily			Allergy/Hive
		Blood Disease			Osteoporosis
		Blood Transfusion			Sinus trouble
		Cancer (when ______)			Head Injuries
		Kidney Disease			Excessive Bleeding
		Diabetes			Strokes (when _______)
		Glaucoma			Tumor *or* Growths
		Liver Disease			Scarlet Fever
		Hepatitis/Jaundice			Rheumatic Fever
		Emphysema			High / Low Blood Pressure
		Lung Disease			Artificial Joints / Hip
		H.I.V. Positive			By-pass Surgery _______
		A.I.D.S.			Cardiac Pacemaker ______
		Thyroid Disease			Heart Surgery / Murmur
		Chicken Pox			Tuberculosis
		Heart Ailments/Attack			Congenital Heart Disease
		Arthritis/Rheumatism			Cortisone/Steroid TX
		Adverse Drug Reaction			Difficulty in swallowing
		Fainting Spells			Nervous/Mental Disorder
		Stomach Ulcer			Diet Drugs: (phen-fen/redux)
		Epilepsy or Seizures			Eating Disorder
		Psychiatric Treatment			Chemotherapy
		Drug Addiction			Radiation Therapy
		Alcohol Addiction			Syphilis /Gonorrhea VD

Do you smoke? Yes No

Do you use chewing tobacco? Yes No

Do you have any disease, condition, or problem not listed above that you think I should know about?

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For office use only

Medical Alerts:

Reviewed by: ______________________ Date ________

Updated: ______________________________________

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