Smiley Family Dentistry

Medical History and Information

Your answers are for our records and will be confidential.

Patient Name _____ BIrthdate _____

Name of Physician _____ Primary Pharmacy _____

Are you currently under the care of a physician? ☐ Yes ☐ No
Please explain if yes:_____

Do you currently or have you ever had the following medical conditions?

Yes	No	Abnormal/excessive bleeding	Yes	No	Heart Attack
Yes	No	ADHD/ADD	Yes	No	Heart Murmur
Yes	No	Alzheimer's/Dementia	Yes	No	Heart surgery
Yes	No	Anemia	Yes	No	Hemophilia
Yes	No	Angina	Yes	No	Hepatitis
Yes	No	Anxiety	Yes	No	Jaundice or Liver disease
Yes	No	Arthritis	Yes	No	High Blood Pressure
Yes	No	Artificial Heart Valve	Yes	No	High Cholesterol
Yes	No	A.R.V.D.	Yes	No	Infectious Diseases
Yes	No	Autism or Asperger's	Yes	No	Joint Replacement
Yes	No	Asthma	Yes	No	Kidney problems
Yes	No	Autoimmune disease	Yes	No	Leukemia
Yes	No	Behavioral/Mental Condition	Yes	No	Lymes Disease
Yes	No	Blood Disease	Yes	No	Mitral Valve Prolapse
Yes	No	Blood Thinners	Yes	No	MRSA
Yes	No	Blood Transfusion	Yes	No	MS
Yes	No	Breathing problems/Respiratory disease	Yes	No	Osteoporosis/Paget's Disease
Yes	No	Cancer (type _____)	Yes	No	Pacemaker
Yes	No	Cardiovascular Disease	Yes	No	Parkinson's Disease
Yes	No	Congestive Heart Failure	Yes	No	Pregnant- Due date:_____
Yes	No	Damaged Heart Valves	Yes	No	Pre-Medication
Yes	No	Decreased Immunity-drug, disease,transplant	Yes	No	Rheumatic fever
Yes	No	Depression	Yes	No	Rheumatic Heart Disease
Yes	No	Diabetes	Yes	No	Rheumatoid Arthritis
Yes	No	Down Syndrome	Yes	No	Severe headaches/Migraines
Yes	No	Drugs for Osteoporosis	Yes	No	Sinus trouble
Yes	No	Eating Disorder	Yes	No	Sleep Apnea
Yes	No	Emphysema	Yes	No	Spleen removal
Yes	No	Endocarditis	Yes	No	Stroke
Yes	No	Epilepsy	Yes	No	Substance/Alcohol Abuse
Yes	No	Fainting spells or seizures	Yes	No	Thyroid problems
Yes	No	Fibromyalgia	Yes	No	TMJ Disorder
Yes	No	G.E. Reflux/persistent heartburn	Yes	No	Tobacco use
Yes	No	Glaucoma	Yes	No	Tuberculosis
Yes	No	Gout	Yes	No	Ulcers
Yes	No	Hearing difficulties	Yes	No	Vision impaired
Yes	No	Other Medical conditions? Explain: _____			

ALLERGIES

Are you allergic to or do you suffer ill effects from any of the following?

☐ Penicillin ☐ Amoxicillin ☐ Latex/Rubber ☐ Metals
☐ Codeine or narcotics ☐ Aspirin ☐ Ibuprofen ☐ Sulfa
☐ Antibiotics _____ ☐ Other _____

MEDICATIONS: Please list any medications, including OTC, "natural", or supplement

_____

_____

_____

Signature _____ Date _____