Center Plaza DENTISTRY

x_____
Initial

MEDICAL INFORMATION

Medical Group/Doctor_____ **Phone Number**_____

Name of former Dentist:_____**Phone Number**_____

List all the medications or drugs you are taking:

[ ] None
_____
_____
_____
_____

Check medications or drugs you are allergic to:

[ ] None
[ ] Aspirin
[ ] Codeine
[ ] Erythromycin
[ ] Latex Rubber
[ ] Local Anesthetics
[ ] Metals
[ ] Penicillin
[ ] Sulfa Drugs
[ ] Vicodin
[ ] Food/Dairy
[ ] Other:_____

Check any medical conditions you may have:

[ ] None
[ ] AIDS/HIV
[ ] Alcohol/Drug Abuse
[ ] Anemia/Leukemia
[ ] Anorexia/Bulimia
[ ] Arthritis
[ ] Asthma/Hay Fever
[ ] Blood Clotting Problems
[ ] Blood Transfusion
[ ] Bronchitis
[ ] Cancer/Tumor or Growth
[ ] Cardiac Pacemaker
[ ] Chest Pain Upon Exertion
[ ] Damage Heart Valve
[ ] Diabetes
[ ] Emphysema
[ ] Epilepsy
[ ] Fainting Spells/Seizures
[ ] Fever Blisters/Herpes
[ ] Frequent Headaches
[ ] Frequently Dry Mouth/Sjogren
[ ] Gall Bladder Trouble
[ ] Heart Attack/Stroke
[ ] Heart Disease/Angina
[ ] Heart Murmur
[ ] Hepatitis/Jaundice
[ ] High Blood Pressure
[ ] Hives/Skin Rash
[ ] Joint Replacement, Date_____
[ ] Kidney/Bladder Trouble
[ ] Liver Disease
[ ] Low Blood Pressure
[ ] Mental Health Problems
[ ] Mitral Valve Prolapse
[ ] Persistent Diarrhea
[ ] Rheumatic Fever
[ ] Rheumatic Heart Disease
[ ] Sexually Transmitted Disease
[ ] Sinus Trouble
[ ] Stomach Ulcers
[ ] Thyroid Problems
[ ] Tuberculosis
[ ] Other_____

Women: Are you pregnant or think you could be pregnant? [ ] YES Months _____ [ ] NO

Are you currently nursing? [ ] YES [ ] NO

Tobacco Use? [ ] YES [ ] NO If so, what kind and how much?_____

Unusual reaction to dental injections? [ ] YES [ ] NO Are you in pain? [ ] YES [ ] NO

Reason for today's visit _____

Before any procedure, do you need to be Pre-Medicated? [ ] NO [ ] YES, Reason_____

By signing below, I certify that all of the above information is true to the best of my knowledge.

Patient/Guardian Signature_____Date_____

Doctor_____Date_____