Center Plaza DENTISTRY

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can
If you have any questions we'll be glad to help you.

## MEDICAL INFORMATION

**Name of Medical Doctor**_____**Phone Number**_____

**Address**_____**City**_____**State**_____**Zip**_____

**List all the medications or drugs you are taking:**

[ ] None

_____

_____

_____

_____

**Check Medications or drugs you are allergic to:**

[ ] None

[ ] Asprin
[ ] Codeine
[ ] Erythromycin
[ ] Latex Rubber
[ ] Local Anesthetics
[ ] Metals
[ ] Penicillin
[ ] Sulfa Drugs
[ ] Vicodin
[ ] 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
[ ] Other_____
[ ] 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
[ ] Hepatitus/Jaundice
[ ] High Blood Pressure
[ ] Hives/Skin Rash
[ ] Joint Replacement, Date_____
[ ] Kidney/Bladder Trouble
[ ] Liver Disease
[ ] Low Blood Pressure
[ ] Mental Health Problems
[ ] Mitral Valve Prolapse
[ ] Persistant Diarrhea
[ ] Rheumatic Fever
[ ] Rheumatic Heart Disease
[ ] Sexually Transmitted Disease
[ ] Sinus Trouble
[ ] Stomach Ulcers
[ ] Thyroid Problems
[ ] Tuberculosis

Tobacco Use? If so, what kind and how much?_____

Unusual reaction to dental injections?_____

Reason for today's visit _____Are you in pain? [ ]Y [ ]N

Name of former dentist:_____Phone Number_____

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

Patient/Guardian Name (printed)_____

Patient/Guardian Signature_____ Date_____

### Updated Medical History

Has anything changed with your Medical History [ ] Y [ ] N

If yes, what has changed? _____

Signature_____ Date_____

Witness_____ Date_____